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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Positive Uses of Hospitalization

Hope for the Epileptic Child

Why So Few Negro Adoptions?

Homemaker Service in Neglect, Abuse

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CLOSE HUMAN CONTACT, a prime need of all babies, is here provided to a sick child by a student nurse. How a hospital in Boston attempts to help children not only to cope with the crises of hospitalization but also to derive emotional strength from the experience is described in the article on pages 3–8.

◂ *the authors*

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Some observations in a children's hospital which point up . . .

CONSTRUCTIVE USES OF A HOSPITAL EXPERIENCE

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IN THE PAST DECADE pediatricians and others who serve children have become increasingly concerned with the effects of hospitalization for physical conditions upon the mental health of children. This concern has been reflected in books by John Bowlby[1] and Emma Plank;[2] in articles by William Langford,[3] Lucie Jessner and Samuel Kaplan,[4] and Dane Prugh;[5] and in recent films by James Robertson[6] in Britain, and Edward Mason[7] in this country.

With the growing recognition of the possible traumatic effects of hospitalization, pediatric hospitals are making increased efforts to attend to the mental health of their reluctant charges. Many sources have suggested changes in hospital procedures, administrative structure, and emotional climate to prevent or lessen the traumatic effects. Some examples: preparing the child for the hospital and for elective surgery; rooming in for the mothers of children under 5; bringing along the favorite toy; liberalized visiting hours; playrooms for ambulatory children; urging parents to be present when the child awakens from surgery; and helping children act out their operations or express their feelings.

Based on a paper prepared as background for a workshop at the 1964 annual meeting of the American Orthopsychiatric Association.

At the Boston Floating Hospital, we noticed that for some children hospitalization was a constructive experience which seemed to facilitate rather than impair their growth. Some children thrived in the hospital and became upset only at the time of discharge. Other children, during the diagnostic workup and prior to any medical treatment, showed a diminution or even complete absence of the physical symptoms, such as abdominal pain, which led to their hospitalization. (The diagnostic and therapeutic implications of this have been noted by Paul Laybourne and Herbert Miller.[8]) Still other children showed marked psychological improvement without any conscious effort on the part of the staff. These cases caused us to wonder how the hospital could be of emotional benefit to more children.

A concern for the welfare of the total child requires not only preventing and neutralizing the possible traumatic effects of hospitalization, but also trying to discharge children from the hospital in a stronger condition, emotionally as well as physically. The child needs to be helped to develop effective mechanisms to cope with the crisis of hospitalization.

The Boston Floating Hospital is an 80-bed inpatient, general pediatric unit of the Tufts New England Medical Center. It was among the first pediatric hospitals in the country to establish a playroom as part of its facilities.[9, 10] At present, the playroom is staffed by four full-time, trained nursery

The director of the playroom at the Boston Floating Hospital helps fill the gap for three young children temporarily deprived of their parents' emotional support.

school teachers and is administratively part of the hospital's child psychiatry unit.

One important aspect of a constructive emotional climate for the hospitalized child is the opportunity to satisfy basic emotional needs through close relationships with one or more persons in the hospital. Bringing this about usually requires knowledge on the part of the staff of the psychological development and needs of children of various ages. Sensitive personnel may make appropriate responses to children on an intuitive basis; however, deeper understanding makes available to them a wider range of appropriate reactions.

The recognition of children's needs for close human contact has led many pediatric hospitals to encourage nurses caring for infants to hold and cuddle them whenever possible, especially at feeding times. The importance of cuddling seems obvious in the case of infants, but it can be equally important for older children, and most important for deprived and regressed children. At the Boston Floating Hospital, the most striking examples of the need for an intense mothering relationship are seen in children admitted for medical evaluation who have had a long history of emotional deprivation. In these cases, one teacher from the playroom staff is assigned to give the child special attention. The results of this consistent and intensive mothering are often dramatic, as in Arthur's case:

Arthur was 2 years old when he came to the hospital for medical evaluation prior to placement in his fourth foster home. At admission, he showed little affect, was withdrawn, and did not speak. There were no positive physical findings, but there was some suspicion of mental retardation. Formal psychological testing was not possible because of the child's limited responsiveness. One nursery school teacher gave Arthur special mothering during his 2 months in the hospital.

For the first few weeks Arthur clung to his teacher. He looked extremely apprehensive, whimpered often, frequently cringed when others came near, curled up on the floor, and sucked his thumb. The teacher held Arthur, cuddled him, talked to him, fed and bathed him, changed his diapers, and generally met his regressive dependency needs. After a while, Arthur, despite marked ambivalence, slowly developed an intense relationship. He began to smile when his teacher appeared in the morning and to show signs of distress when she absented herself for even a few moments.

Over the 2-month period the change in Arthur seemed like a condensed version of a child's development during the first 2 years of life. He began to walk about, attempted to feed himself, and regained control over his bowels and bladder. He began to play with toys and engage in activities more appropriate to his age. Finally, he began to babble and then to speak single words. This was quickly followed by echoing phrases and finally sentences. Psychological testing shortly before discharge showed him to be functioning in the average range of intelligence.

Arthur's new foster parents came to the hospital a week before his discharge. They had observed him in the playroom and were introduced to him by his teacher, who had been preparing him for this event. In repeated and longer visits the child and foster parents became familiar with each other. The foster parents talked with Arthur's playroom teacher, who discussed his background, special needs, and the problems they might encounter, and passed along suggestions on how to manage him in difficult times. By using her relationship with the child, the playroom teacher thus was able to effect the transfer of the child to his new home with minimal signs of disturbance on Arthur's part.

When Arthur left with his new parents, he was smiling, interested, and talkative, in contrast to his regressed behavior on admission. Realizing how many times he had been hurt by the pain of separation, the hospital helped Arthur to see how others could understand and support his efforts to deal with separation.

The emotional climate created in the playroom is extended when necessary to otherwise normal children who are, during hospitalization, experiencing the temporary deprivation of their parents' emotional support. This same mothering approach has also proved effective in other, more subtle, cases of maternal deprivation. In the nursery, for example, children who fail to thrive because of vomiting or refusing to eat, due to tensions in the mother-child relationship, frequently become voracious eaters when mothered consistently by one nurse.

In all situations, the personnel operate on a reality level consistent with their training as nurses and educators. No attempt is made to encourage catharsis, work out unconscious conflicts or promote insight,

though the staff is alert to fears and anxieties and reassures the children when necessary. The playroom staff provides valuable diagnostic information and also meets the emotional needs of children for contact with understanding and accepting persons. This occurs in an atmosphere consciously created to contrast with the severe restrictions of other aspects of hospital life. Frequently what is done is only the first step in a long process of emotional rehabilitation.

Arthur's foster parents have to continue the job the hospital began. Even then one wonders how completely this child can overcome psychic scars left by the severe deprivations he suffered at a critical age. In many cases, followup is necessary and the psychiatric department may work a long time with the family to attempt to alter patterns of parent-child interaction.

Encouraging Normal Growth Patterns

Some children come to the hospital from homes in which their efforts to grow are being thwarted. Sometimes parents are overprotective and keep their children dependent upon them. Other parents react to their child's growth as if it were a competitive situation, threatening their status. Still other parents, having had emotional difficulties themselves as children during a specific stage of psychological development, are unable to tolerate their own child's entering that same developmental phase. When the emotional climate of the hospital permits children to express themselves, this is often enough to unleash the psychological forces that push toward growth.

Jane, aged 13, was admitted following ingestion of poison in a suicide attempt after running away from her foster home. She had got along well with her foster mother for several years but, at the onset of adolescence, began to exhibit difficulties. Jane's natural mother had deserted her when she was 6 and because of this loss Jane had developed a self-image of a needy, inadequate girl who had nothing to offer. Her foster mother, threatened by Jane's developing femininity and needing to keep Jane dependent, encouraged this image.

When Jane entered the hospital she was exactly as her foster mother had described her: sullen, argumentative, irritable, uncooperative, and belligerent. Understanding some of her background and recognizing normal adolescent strivings, the hospital staff provided her with constructive opportunities for adolescent expression.

Noticing her talent for caring for young children, the playroom staff made Jane feel as though she were an assistant teacher and taught her to care for other children. She was given a new hairdo and some bright, stylish clothes, reinforcing her tendency toward feminine adolescent behavior. Her self-worth was heightened, although basic problems were not and could not be worked through.

Jane responded almost instantly to all this. She blossomed with new importance and dignity. She became cheerful, friendly, helpful, and talkative. She related warmly to the female playroom staff who supported her wish to grow up, and eventually she talked with a psychiatrist. The hospital recommended to the social agency that Jane not be returned to her foster home. Arrangements were made to place her in a new setting that would continue to encourage the growth the hospital had initiated.

It was extremely difficult for Jane to leave the hospital, and she expressed strong wishes to stay on. She had developed an intense attachment to the hospital and said she wanted to become a nurse after finishing high school.

Altering Parent-Child Relationships

Most children who come to the Boston Floating Hospital do so because they are physically ill. Once the child is hospitalized, however, serious concomitant emotional aspects are often discovered which complicate the hospitalization. The behavior of parent and child during visiting hours, in wards, or in playroom, may indicate to an alert staff member that a problem or even a pathological relationship exists. The more time a mother and child spend together the more accurate can the assessment of their relationship be.

The pediatric hospitals that allow a mother to live in with her ill child greatly increase the staff's opportunities to observe the mother-child relationship and increase the mother-staff contacts. Sometimes this increased contact can be helpful—when the mother feeds, watches, and comforts the child, or helps another mother. Sometimes it can upset the staff, disrupt the child's medical treatment, and cause serious management problems—when the mother is overly worried, too controlling, overly protective, or excessively suspicious. An especially difficult mother can embitter the staff's opinion of the living-in arrangement. Such cases, especially with mothers of older children, may signal a problem in the parent-child relationship or a disturbance in the parent alone. If the staff cannot deal effectively with such a mother, the child himself may feel helpless and be caught between the expectations of parent and staff.

The hospital can view such a situation not as a nuisance and an irritation but as an opportunity to attempt to alter a problem parent-child relationship. Not only can it encourage emotional growth, but it can also actively refuse to support growth-defeating interactions. Sometimes all it can do is to present reality and impose limits. At other times, it can evaluate the situation and actively try to bring about changes.

Mary, 12 years old, had a serious, though not immediately dangerous, illness. Her mother insisted on living in and very quickly alienated the staff. She refused to let the physicians

and nurses near Mary until they explained every detail of what they were going to do. She questioned every staff decision. The child refused to eat unless spoonfed by the mother and wept bitterly whenever the mother was out of her sight. The mother made such gloomy pronouncements in the child's presence as: "Mary is ready to meet her Maker." Mary was terrified and did not respond to treatment. The staff seemed helpless in dealing with this mother and, in despair and anger, asked for a psychiatric consultation.

Meanwhile, Mary developed a fever and was transferred to a contagious ward as a precaution. The new nurse saw the pathology in this relationship and felt a separation could be effected. This ward had no facilities for living in and the nurse informed the mother that she would have to go home. She also imposed a limit of a 1-hour visit per day. She told the child she was perfectly capable of doing things for herself. Parent and child protested, but the nurse stood firm and the mother left. Within a few days the girl was feeding herself, smiling, and acting more like a normal adolescent. Her physical improvement was rapid. The hospital's social service department guided the mother to a social agency to arrange for Mary's convalescent care.

We do not know whether the change in this mother-child relationship is permanent, but when discharged Mary and her mother were getting along better, even though the visiting hours had been liberalized. The important thing is that this mother and child changed their behavior to conform to the staff's wishes once limits were set. The hospital did not accept, and thus maintain, a problem relationship between parent and child.

Refuge From an Emotional Storm

We usually think of a hospitalized child as being torn away suddenly from a secure and stable home environment and thrust into a new and frightening world. Sometimes the reverse is true. John Rose and Meyer Sonis [11] have observed that the hospital can be a refuge from an intolerable home situation. It may be a relatively stress-free environment—a haven for the child while the disturbing home situation is being evaluated and resolved by the social service department. If the hospital staff accepts the child as he is, and makes demands that are consistent with his ability to respond, he can visibly change after a few days. In these cases, presenting symptoms often disappear, sometimes to reappear on the day of discharge.

Fred, aged 10, was admitted for evaluation of possible brain injury. He was actively hallucinating. Subsequent medical workup revealed no organic pathology or physical illness. The psychiatric evaluation revealed a bizarre home situation with a borderline psychotic mother. The home was in a constant state of tension, with much sexual and aggressive acting out. Both parents said they were unable to control Fred.

Fred received no active treatment in the hospital. The focus was on the demands of reality. His hallucinations quickly disappeared, his anxiety level dropped; and he presented no management problem on the ward. Meanwhile, the psychiatric team worked with the parents. When Fred was discharged, outpatient psychiatric treatment was instituted for the family. The hospital's intervention and support helped to reduce the tension in the home to a point where the returned child could experience no regressive symptoms. Continued psychiatric care by the hospital's outpatient unit was lengthy, but a possible psychiatric hospitalization or foster home placement was avoided.

Accepting the idea of the hospital as a refuge has a very important consequence: It means that sometimes a child may be detained in the hospital for therapeutic reasons after completion of the diagnostic workup and medical treatment. The hospital's emotional climate may be a healing force; though physically able to be discharged, a child may need emotional convalescence. Fred, found to have no organic pathology, could have been discharged. But discharge was delayed until the psychiatric team felt the family could tolerate his return—a matter of a week. The emotional consequences of a premature discharge could have been disastrous.

Opportunities for Identification

The hospital's emotional climate can be such that both parents and children can learn patterns of mothering through identification with staff members. Jane's case demonstrated how an adolescent girl identified with the mothering role of the playroom personnel.

The case of Mrs. Smith shows how a basically healthy parent, temporarily overwhelmed by crisis, can identify with and be taught effective mothering by a nurse:

Mrs. Smith was rooming in with her only child, a month-old son having a hernia repaired. The nurse noted the mother was very tense in feeding the child and very fearful in handling him. The fear seemed to be related to lack of knowledge about the child's physical illness and the fact that Mrs. Smith was a new mother. The nurse explained the child's illness, respected the natural anxieties of motherhood, and provided education and encouragement. Within a few days, Mrs. Smith was more relaxed during feeding.

Because of the many pressures of a busy hospital, nurses and doctors frequently overlook opportunities to teach constructive patterns of child care and to allay parental anxieties. Albert Solnit [12] has discussed the importance, in the living-in situation, of having the staff help to deal with the crisis of hospitalization, so that it can become a growth experience to both mother and child.

Identification with staff can also broaden a child's vision of vocational choice.

For late adolescents a special value of the hospital

is the chance to observe and investigate diversified vocations which may help them make a career choice. A child whose hospital experience was unpleasant and terrifying may have been a potential doctor or nurse now lost to the profession (unless the child identifies with the doctor as one who hurts instead of heals, an undesirable trait in the "caring professions").

Some children, especially older ones who have had a constructive hospital experience, express wishes to become physicians, nurses, technicians, and so forth. Often these wishes are just passing fancies, but sometimes they result in actual vocational choices.

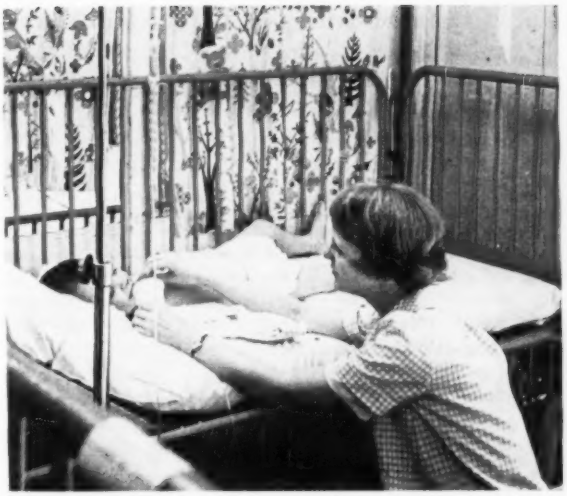
A hospital has many special educational resources and is a unique schoolroom.[2] Schoolwork should be continued whenever possible for children hospitalized more than a few days. The hospital has many opportunities for children to learn about the physical and biological sciences, such as in diagnostic and research laboratories. The use of the hospital in this way might be considered for older children who face long-term hospitalization. Plank [2] gives an excellent example of a 16-month tutoring program for a 13-year-old boy in the biological and physical sciences. This program stimulated the child and counteracted the isolation and depression brought on by a long hospitalization, much of it in a respirator.

Emotional Education in the Hospital

One essential aspect of a constructive hospital experience is to create a balanced emotional climate in which it is possible to learn by asking questions. Too often a child's questions about his illness, body, medical procedures, and the like are not answered. Hospital staff members often fail to understand the importance to children, especially those of school age, of intellectual attempts to master anxiety. Frequently, not only is the child denied an opportunity to achieve this mastery, but also his anxieties and fears about what is happening to him are increased by staff failure to recognize his natural curiosity.

The hospital can allay the child's anxieties about body processes, fluids, organs, and illness. Physical illness frequently exacerbates body concerns and preoccupations, especially those related to fantasied punishment for bad behavior. The hospital is uniquely qualified to educate the child about his body and illness and can sometimes help alleviate guilt and anxiety. An alert nurse performed this function in the following case:

A 12-year-old girl was admitted for fainting spells, dizziness, vomiting, and mood swings of 1 week's duration. Physical findings were negative. It was discovered that menarche had begun just 1 week prior to admission. The child showed considerable anxiety and guilt over this unexpected and unexplained occurrence. A nurse, with whom the girl felt comfortable, took the opportunity to discuss sexual maturation and answered her many questions. A noticeable improvement in the girl's symptoms occurred.



The young woman feeding this sick child is one of several non-medically-trained child care workers hired by the Boston Floating Hospital to "mother" its young patients.

When staff members take the time to listen to hospitalized children, they are often amazed at the torrent of questions. Many questions, of course, relate to the child's illness, his body, and what is happening to him. However, except for children so critically ill that their entire attention is focused on themselves, ill children are curious about the entire hospital world, both human and physical. They want to know what a germ is, why nurses wear different hats, why Johnny has his head bandaged, what an X-ray or brain wave is, why pain hurts, why Billy died (and are they sick like he was), when their parents are coming to visit, when they can go home, why the nurse has to take blood from their finger, and on and on. Talking with the child can calm specific fears and contribute to his long-range education and development. Many families have difficulty allowing children to ask questions about anxiety-provoking areas. Some parents are often greatly relieved when a responsible agency helps them deal with subjects like illness, death, and sex that they have been unable to face with their children.

For example, a child's questions about what is wrong with some other patient provides an oppor-

tunity to help him develop empathy for persons with special handicaps—mental retardation, neurological impairment, loss of limbs, blindness, other bodily disfigurements, and emotional illness. In a constructive emotional climate, every attempt is made to answer such questions at the appropriate time in a manner consistent with the child's understanding.

Billy, 12 years old, was admitted for seizures, severe behavior problems, and learning difficulties at school. His parents, the school, and a child guidance clinic were unable to deal effectively with his violent temper tantrums. His peer relationships were poor, for he frequently assaulted children. While hospitalized, he developed an affection for a 6-year-old, grossly overweight boy who also had a behavior problem himself—whining, crying, screaming for food and his mother, and throwing violent tantrums whenever a doctor or nurse came near him. Taking a blood sample on this 6-year-old was a major procedure, but Billy had the amazing ability to get him to behave. With Billy at his side, the child would hold out his hand for the technician to take blood. Soon the staff was using Billy to accompany the boy to X-ray, blood labs, examining rooms, all done without a whimper from the boy. "There's nothing wrong with him," Billy said, "except that he's scared of doctors. I know just how he feels."

When the hospital encouraged this relationship, Billy developed techniques for relating positively, revealed empathy, and gained some insight into the relationship between fear and aggressive behavior.

Hospitalized children frequently soil, wet, suck their thumbs, and regress in other ways, and are extremely anxious about their need to do these things. One of the most constructive emotional experiences the hospital can offer is permission for, and acceptance of, the child and his regressive symptomatology. Regression, often a necessary part of illness, is difficult for staff or patient to accept. It is even more disturbing to a child because he almost always sees it as a threat to his autonomy and recent hard-fought struggles to grow up. The accepting climate created by adults around him can help the child accept himself. In this way it contributes to the child's total personality development and recuperative process.

A serious concern for the total welfare of the hospitalized child requires that we give more thought to the constructive role the hospital can play in a child's emotional growth. This is crucial because so few children completely escape a hospital experience. Previous work has focused on alleviating or neutralizing the potentially traumatic effects of hospitalization; however, it is not enough to discharge a child as physically healthy but emotionally unchanged. Hopefully, a child can leave the hospital also stronger emotionally. While a child psychiatry unit in the hospital may help to create a positive climate, hospitals without such units can still create a therapeutic atmosphere. This view may be an ambitious one, but as a 6-year-old patient said: "The most important thing about this hospital is *ME*."

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. . . It is all very well for the man who is surfeited with all the choices of our lavish market place to wonder about the materialistic values of our affluent society. But the man who can't afford to buy even the cheapest meat, or pay his child's doctor's bills, or keep his youngster in high school also cannot afford the luxury of this kind of speculation. . . .

—Elizabeth Wickenden, Technical Consultant on Public Social Policy, National Social Welfare Assembly, to the annual meeting of the Community Health and Welfare Council, Cincinnati, April 1964.

Thirty years of treating children who suffer from seizures provide some answers to the question . . .

WHAT HOPE FOR THE CHILD WITH EPILEPSY?

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WHEN I BEGAN to treat epilepsy approximately 30 years ago, the number of patients whose seizures were controlled sufficiently to enable them to function normally was relatively small—probably less than 10 percent in our clinic, the Johns Hopkins Hospital Epilepsy Clinic. Twelve years later, in 1946, we found that 17.4 percent of a group of epileptic patients who had been followed in the clinic for at least 15 years had been seizure free for more than 5 years.[1]

We are currently in the process of determining the incidence of seizure control in 15,104 epileptic patients who have been followed in the clinic during the past 30 years. Although the study has not yet been finished, the figures on hand thus far indicate that complete seizure control was obtained in approximately 60 percent of the patients; in another 25 percent, the seizures were reduced in frequency enough to make it possible for the patient to live a fairly normal life. In the remaining 15 percent of the patients, the seizures resisted all forms of anticonvulsant therapy.

In addition to the marked increase over the years in the number of patients whose seizures have been satisfactorily controlled, we have also observed a gradual improvement in the general well-being of patients with epilepsy, particularly a marked diminution in the number and magnitude of emotional difficulties.

The improvement in the overall outlook for persons with epilepsy may be attributed to such factors as: diagnostic advances, therapeutic advances, improvement and expansion of services, and modification of restrictive legislation.

Diagnostic Advances

Electroencephalography—a method for recording the electric activity of the brain, introduced in this country in the late thirties—has played a major part in bringing about a better outlook for the epileptic patient. It has done this in four ways:

1. It supplies information of significant diagnostic value to the physician in instances in which a definite diagnosis cannot be made on clinical grounds—for example, in cases in which the clinical history of a seizure is vague or questionable, or in cases of patients with nonconvulsive symptoms such as recurrent dizzy spells or recurrent fainting spells. Prior to the advent of electroencephalography, these nonconvulsive manifestations were frequently classified as functional disturbances if no organic basis for the symptoms could be found.

2. It is exceedingly valuable in classifying the

various types of epileptic seizures. Ability to distinguish between the various types of epileptic seizures is important, because drugs which are capable of controlling one type of seizure may be ineffective against other types, or may, in fact, increase their frequency. For example, Dilantin, which increases the number of petit mal spells in some patients, is one of the most effective agents for the control of psychomotor spells. And Tridione, which is very effective in the control of petit mal spells, is ineffective in treating psychomotor seizures.

The inexperienced physician may have considerable difficulty in clinically differentiating a petit mal spell from a brief psychomotor seizure. However, the electroencephalogram (EEG) almost always provides information which assists the physician in differentiating these two types of seizures. The EEG of petit mal epilepsy shows abnormalities consisting of the classic diffuse bilaterally synchronous spike and wave dysrhythmia, whereas the EEG of psychomotor (or temporal lobe) epilepsy usually reveals electrical aberrations, generally spikes, which are limited to the temporal areas of the brain.

3. Electroencephalography is particularly important to the neurosurgeon, since it frequently provides information which assists him in localizing epileptogenic foci.

4. In the research laboratory, the electroencephalograph has probably done more to clarify the problems of seizure disorders than any other discovery of the past 25 years.

Therapeutic Advances

Drugs and Therapeutic Regimens. Prior to 1939, the only antiepileptic drugs of any value were bromides and phenobarbital. However, in the past 25 years a number of new anticonvulsant drugs have been introduced and successfully employed against seizures. They include Dilantin (1939), Tridione (1944), Mysoline (1952), and Zarontin (1961).

Improved technique in the administration of the ketogenic diet regimen (a high fat, low carbohydrate diet) has also contributed to the better outlook for the child with epilepsy. This regimen, which produces an abnormal number of ketones in the body, is most effective in the control of epileptic seizures in young children.[2]

Although the surgical treatment of epilepsy cannot today be recommended for more than a fraction of the epileptic population, good results have been obtained in carefully selected cases.[3] However, increased interest and improvement in surgical techniques indicate that more frequent good results from surgery will eventually be obtained.

Early Treatment. In the past, physicians did not usually make a diagnosis of epilepsy until the patient had experienced many seizures. Today, however, most physicians seriously consider such a diagnosis after the patient's first convulsion of undetermined origin. In our clinic, we immediately prescribe daily anticonvulsant medication to all patients who have had one epileptic seizure.[4] We have found that the degree of success in the control of seizures bears a direct relationship to the duration of the epilepsy: the longer the patient has been having seizures, the less likely it is that a satisfactory result will be obtained. Early measures to prevent a recurrence of seizures are important, not only for future seizure control but also to prevent the injuries, brain damage, and emotional disorders which sometimes result from seizures.

Prolonged Therapy. Years ago, it was the general policy of our clinic to discontinue medication about a year after the patient's last seizure. Later, the duration of therapy was increased to continue for 2, 3, and then 4 years after the last seizure. This was followed by a considerable reduction in the number of patients who had seizure recurrence. Today, we continue medication for at least 4 years after the patient has been free of seizures and, in some instances, particularly with adults, for the rest of the patient's life. The longer anticonvulsant therapy is continued, the less likely a patient is to have a recurrence of seizures after therapy ends.

Gradual Withdrawal of Medication. Some physicians—myself included—used to withdraw effective antiepileptic medication either abruptly or over a very short period. However, observations have shown the importance of gradualness in withdrawing antiepileptic medication if freedom from seizures is to be maintained. A sudden withdrawal is a frequent cause of seizure recurrence or of status epilepticus, a state of continuous convulsions.

The length of the withdrawal period is governed by the amount and type of medication the patient had been taking—usually 1 to 2 years in patients who have been taking an average amount of anticonvulsant medication. A gradual withdrawal is particularly important in cases of major motor (grand mal) seizures.

Treating the Whole Patient. About 30 years ago,

the treatment of epileptic patients in most clinics, including our own, consisted almost exclusively of giving the patient some type of medication and telling him to return later if his seizures were not helped. As time went on, clinicians began to realize that medical attention should be directed not only to the seizures *per se*, but to the "whole individual," since the epileptic patient frequently has many other problems related to his seizure disorder. We soon learned that when we took the time to sit down with the patient or his parents, or both, and gave them the opportunity to discuss their problems—emotional, medical, and socioeconomic—our overall results became progressively better. Now we believe that the consideration of such problems as how to cope with epilepsy, how to get schooling, and what the future holds is just as important as the administration of antiepileptic medication. In dealing with these problems, the physician now works closely with members of other professions, such as social workers, psychologists, and public health nurses.

Improved Services

Specialized Epilepsy Clinics. When I began working with epileptic patients, few clinics in this country offered specialized care to children with epilepsy; most of them were treated in the general dispensaries. Also, relatively few physicians showed special interest in epilepsy. In fact, many patients were receiving their treatment from mail-order drug houses.

One of the most significant advances made in behalf of epileptic children has been the development of epilepsy programs as a part of federally aided State services for crippled children. Twelve times as many children received care for epilepsy through these programs in 1963 as in 1950, according to reports made to the Children's Bureau. In 1963, 33 States accepted children with epilepsy for service, as against only 17 States in 1950. The service varies in comprehensiveness from State to State—ranging from a diagnostic workup of an occasional child to a multidisciplinary service which provides diagnosis, treatment, and followup care for children in all parts of the State.

In my own State of Maryland, all children with seizures can receive expert diagnostic evaluation and regular followup care through the State epilepsy program, which began operation in 1950 as part of the State crippled children's services. Routine followup is regarded as especially important, since the patient needs to be seen regularly to have the dosage of his medication adjusted, to be examined for drug reactions, and to have an opportunity to discuss his special problems.

Prior to the institution of the Maryland epilepsy program, specialized medical care was not readily available to many children afflicted with epilepsy, particularly those residing in rural areas. Now, however, under the Maryland epilepsy program, epileptologists from the medical centers conduct clinics at regular intervals in the various rural counties of the State. The program also offers consultation services to the local practitioner in both rural and urban areas. It has been responsible not only for improvement of medical care for all epileptic children in the State but also for a better understanding of epilepsy by the public, thereby helping to eliminate some of the many unwarranted stigmas associated with epilepsy.

Increase in Physicians Treating Epilepsy. Obviously, an individual with any medical disorder should consult his personal physician about "what to do and what not to do." While for many years the medical profession considered epilepsy to be entirely a problem for the psychiatrist or the neurologist, in recent years more and more general practitioners and pediatricians have become interested in, and have learned more about, the disorder. This is progress in the right direction. Since epilepsy is a disorder of childhood—approximately 90 percent of patients experience their first seizure during childhood—the pediatrician or the general practitioner is usually the first physician to be consulted after the first seizure occurs. Therefore, the patient would be most likely to receive appropriate therapy at an early date if the pediatrician or family physician considered epilepsy to be within his competency.

I believe that most pediatricians and general physicians can adequately care for a child with epilepsy. Of course, in some instances they may desire to consult a neurologist or a physician who specializes in convulsive disorders to establish a diagnosis and to assist in the management of the more complicated cases.

Lay Organizations. In recent years, a number of lay organizations have been established which offer important services both to the epileptic patient and, in many instances, to his physician. These services include referral to appropriate resources, personal counseling and information, research, professional consultation, professional and public eduction, development of educational and job opportunities for patients, and social action to modify legislation

which discriminates unnecessarily against persons having epilepsy. By associating with one of these organizations, the epileptic patient not only can gain much personal help, but also can contribute to a better general understanding of epilepsy. At the same time, he is likely to gain emotional support from the knowledge that national attention is concentrated on his type of disorder and its associated problems.

At this writing four national voluntary lay organizations concerned with epilepsy are operating in the United States: the American Epilepsy Federation, Quincy, Mass.; the Epilepsy Foundation, Washington, D.C.; the National Epilepsy League, Chicago, Ill.; and the United Epilepsy Association, New York, N.Y. Each organization has local chapters in various communities throughout the country. A movement is now in progress to amalgamate the four into one national organization to be called the Epilepsy Association of America. This would eliminate much unnecessary duplication of effort and resultant confusion.

Modification of Legislation

Within recent years, a number of States have repealed or modified laws and policies which denied to persons with epilepsy normal human rights such as marriage, having children, going to school, and choosing their occupation. Such restrictions were put on the statute books or in official regulations at a time when heredity was thought to be the major causal factor in epilepsy and when drugs for controlling seizures were not available. However, in spite of the fact that today the genetic factor in epilepsy is thought to be small,[5] four States still have laws prohibiting the marriage of persons with this disorder. More have laws requiring their sterilization, but these are only rarely enforced. Other official policies—statewide or local—restrict the employment and educational opportunities of epileptic patients even after their seizures have been controlled.

Such restrictions should be abolished or modified to allow for consideration of the condition of the individual. Their sweeping nature serves no real social purpose and adds considerably to the emotional difficulties of persons with epilepsy by preventing them from living normal lives and by supporting the stigma attached to epilepsy in many people's minds. Most of the emotional disturbances observed in patients with this disorder are not manifestations of the disorder itself, but are results of a hostile society which has discriminated against them since the dawn of recorded history.

Happily, the attitude, "once an epileptic, always an epileptic," has been abandoned by most motor vehicle commissioners and their medical advisory boards; today, in most States, a person whose epileptic seizures are controlled is allowed to operate a motor vehicle. This not only has a favorable psychological effect on the individual, but often helps him advance his economic status because of the many types of employment it opens up.

Goals Ahead

In spite of the advances in the management of epilepsy in the past few decades, many goals have yet to be attained:

1. A major goal is to ***determine the cause*** of the disorder. True, the advent of electroencephalography has greatly assisted in classifying specific types of seizures, and the ingenious investigations of medical researchers, such as Ajmone-Marsan, M. Baldwin, Gastaut, the Gibbses, Lennox, Penfield, Jasper, and Walker, have produced significant information regarding the presumptive site of seizure origin in many patients. But the specific cause of epilepsy remains undetermined.

Some investigators assert that brain damage is the cause. Certainly brain damage plays a part in some cases. However, I do not believe that brain damage *per se* is the sole cause of epilepsy.

True, acute brain damage, either from trauma or infection, is frequently accompanied by a seizure. Residual brain damage, however, cannot be the sole cause of recurrent epileptic seizures for two reasons: (1) all individuals who sustain brain damage of a similar nature do not develop epilepsy—for example, only 25 to 30 percent of patients with cerebral palsy have epileptic seizures; and (2) if permanent brain damage were the only cause of recurring epileptic seizures, the afflicted individual would be in a constant state of seizures, since the brain damage is present at all times.

However, since recurrent seizures do develop very frequently in individuals after they have sustained brain damage, this may be regarded as a predisposing factor in epilepsy. It is reasonable to assume that a given individual might never have developed epilepsy had he not sustained brain damage, although one can never be completely certain of this. In some manner, it seems, brain damage lowers the individual's convulsive threshold.

Another hypothesis as to the cause of epileptic seizures focuses on disturbances which produce defects in the physiological, metabolic, enzymatic, or

chemical systems of the brain. No significant evidence has been presented, to my knowledge, which definitely proves that any one, or a combination, of these cerebral defects is unquestionably the cause of epilepsy.

Some physicians classify all persons with epilepsy, regardless of their mental status or the absence of neurological deficits, as brain-damaged individuals merely on the basis of the occurrence of epileptic seizures. True, some persons with epilepsy have brain damage, and some patients with epilepsy are mentally retarded. However, the vast majority of patients with epilepsy have at least normal intelligence and do not manifest any neurological evidence of damage to the brain. Moreover, post-mortem examinations and gross anatomical and microscopic studies performed on the bodies of many patients who had epilepsy have not revealed evidence of damaged brain tissue.

I believe that to classify a person who has recurrent epileptic seizures as "brain damaged" or "brain injured" merely on the basis of the seizures themselves is not medically sound. If continued, the close association of brain damage with mental retardation in the minds of the laity can push epilepsy "back into the closet" from which it has just started to emerge. It seems more appropriate to classify an individual with epilepsy as one suffering from "transient states of cerebral dysfunction of unknown cause."

2. ***Statewide projects*** similar to the Maryland epilepsy program are needed in *all* States. Since epilepsy is one of the most common of the disorders which have a tendency to be chronic, systematic regular care should be available to every epileptic child as it is for children with some other types of chronic disorders such as cerebral palsy.

3. ***More research is needed.*** The vast majority of patients with major motor (grand mal) seizures can satisfactorily control their seizures with the antiepileptic agents now available. The same is true to a lesser degree of patients with petit mal epilepsy. However, the current therapeutic armamentarium is not very effective for the treatment of the other two common types of epilepsy: psychomotor (or temporal lobe) and minor motor (infantile spasms, hypsarrythmia). Thus there is much need for continued research to find new therapeutic agents for the control of these two types of seizures. Significant investigations of new anticonvulsants are now being conducted by several large pharmaceutical manufacturers.

4. There is great need for ***improvement in society's attitude*** toward the disorder of epilepsy. Many persons are still imbued with the many misconceptions about epilepsy which were so prevalent in the past. Because of this, epilepsy still remains one of the "hush-hush" diseases. The activities of the lay epilepsy organizations constitute one of the most effective means of dispelling the stigmas associated with the disorder. They should be even more effective when these organizations combine.

5. The major difficulty encountered by persons with epilepsy is ***securing employment.*** This is due mostly to the fact that many employers believe that all persons so afflicted are less proficient and more prone to accidents than normal workers. This notion has no medical or statistical basis. On the basis of my observations of thousands of persons with epilepsy, I would guess that, on the contrary, the accident rate of the selectively placed epileptic worker is less than that of the non-epileptic worker, and that his work efficiency is at least equal and, in many instances, superior to that of the normal person.

Many employers I have talked to seem to think that the workmen's compensation law prohibits the employment of individuals with epilepsy. Actually, *no* provisions in the workmen's compensation law, or rates set under it, penalize an employer for hiring persons with any type of handicap. Of course, some persons with epilepsy are inappropriate candidates for employment. This does not make it necessary to apply the designation "unacceptable" to the entire epileptic population.

There are at least 2 million persons with epilepsy in the United States. In this day when the importance of "equal opportunity" for all is stressed, they should not still be classified as "second-rate citizens." They should be assessed in the same manner as any other individuals; that is, according to their physical and mental ability to function in society.

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A reappraisal of evidence . . .

WHY SO FEW NEGRO ADOPTIONS?

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THE LACK of adoptive homes for Negro children in need of placement is a problem familiar and painful to persons concerned with the welfare of children. About 70 percent of the white children born out of wedlock are adopted, as compared with less than 10 percent of the nonwhite children.[1]

The painful aspect of these figures lies in evidence about the fate of many children born out of wedlock who are not adopted. No doubt a considerable number are absorbed into the maternal family without serious adverse effects. Some, however, remain indefinitely in institutional or foster family care; and frequent replacements of such children are not uncommon.[2] Some children born out of wedlock remain with mothers who are unable or unwilling to care for them adequately, and who may not have access to the services they need to help them become more effective parents. For example, a mother may need to work to support her child but be unable to provide him with adequate supervision while she is out of the home.[3] Or keeping the child at home may interfere with a young mother's obtaining needed schooling for herself, and so the child becomes caught, with her, in the cycle of poverty and dependency associated with poor education and lack of vocational training.

Thus there are solid grounds for concern about the fact that there are many more Negro children in need of adoptive homes than there are couples wanting to adopt them.

A review by the Children's Bureau of available reports on research and demonstrations relating to births out of wedlock has brought out a number of findings and assumptions concerning the need for more Negro adoptive homes and the effectiveness of efforts to stimulate Negro adoptions.[4-14]

Some Assumptions

One assumption, widely current some years ago, is less widespread today: that Negro unmarried mothers seldom, if ever, wish to place their children in adoption. While many Negro unmarried mothers obviously do wish to keep their children, the large number of Negro infants abandoned in the hospitals where they were born is tangible evidence that many do not. In line with such evidence, the executive director of a maternity home for Negro unmarried mothers said, in an informal interview, that 40 percent of the residents ask to relinquish their babies, and that this would probably be closer to 60 or 65 percent if there were any likelihood of the babies being accepted by placement agencies.

Reports from other sources also indicate that desire to relinquish children born out of wedlock far outweighs desire to adopt them. A participant in a recruitment drive for Negro adoptive homes, launched by several voluntary agencies, commented that the first response to the project was not from prospective adoptive parents, but from unmarried mothers wanting to place their babies. This social worker made a

point that is supported by experience as well as by reading between the lines of some research reports: that if unmarried mothers do not believe they will be able to place their children, they do not mention adoption placement when they are asked whether they need or want social services.

Another assumption is still prevalent: that Negro couples are less ready than white couples to adopt children, chiefly because Negroes do not know about the availability of adoption services and of babies to be adopted. A number of projects have attempted to demonstrate the effectiveness of a coordinated communitywide effort to bring to the attention of the appropriate segments of the Negro population the opportunities that exist for the adoption of Negro children. These projects have been based on the premise that the apparent apathy of Negro couples toward the idea of adopting is due primarily to ignorance about the availability of Negro children, misconceptions about application procedures, fear of rejection by prying or prejudiced social agencies, red tape, and the like. Therefore, their major efforts have been directed toward correcting misinformation, or lack of information, and stimulating the interest believed to be latent in the community.

Typically, such projects have used various forms of public education, including spot radio or television announcements, newspaper publicity, speakers' bureaus, bus placards, and informal discussions organized through church, professional, and labor groups in Negro communities. The active participation of Negro community leaders has usually been secured. Direct mailings to members of organizations, and pamphlets and brochures placed in offices of social agencies, doctors' offices, beauty parlors, and barber shops have also been used.

One adoption agency held meetings with Negro couples who had already adopted children, to get suggestions about methods of recruitment based on their experiences. In two projects, mailings were sent to Negro families who were giving foster care to children. In another, meetings were held for Negro adoptive couples and prospective applicants, with the adoptive parents answering the applicants' questions—the theory being that "the best advertisement is a satisfied customer."

In their conclusions, reports of such projects tend to find merit in an organized, consistent, and cooperative community educational program to stimulate interest in the adoption of Negro children. However, some reports are not wholly enthusiastic about the results actually obtained. Moreover, analysis of the figures reported indicates that the numerical increases in applications are modest and suggests that the proportions of dropouts and rejections among applicants are likely to increase during such a drive.

An exceptionally systematic and carefully reported study by Fanshel,[4] based on applications over a 5-year period (1951–55), comments on "the relatively small number of those couples who had come [to the agency] on the basis of newspaper or radio/television [announcements] who went on to adopt a child." Fanshel sees the chief beneficial results of "broad public relations efforts" as indirect and long term, rather than immediate and direct. Like other investigators, he notes improvements in agency morale and "commitment," in interagency communication, and in mutual understanding between agencies and individual professional people, with consequent improvement in referral practices. He reports also that some applicants who withdrew after an initial contact returned later and completed an adoption.

Since most reports are sketchy and since criteria vary from one report to another (and not all give actual figures), there is still room for further inquiry into the sustained effectiveness of such projects and whether it is substantial enough to offset the financial cost, professional time, and community energy they consume. Careful review of the available reports

A young couple with their newly adopted baby. The accompanying article raises some points to question the assumption that Negro couples in a position to adopt are less ready to do so than white couples in similar circumstances.

seems to support the comment of Deasy and Quinn: "Social agencies on both the local and national levels have been trying for years to increase the numbers of Negro children who are legally adopted. But the success of such programs seems to have fallen far short of expectations and aspirations." [5]

Reasons for Not Adopting

After a review of relevant studies and demonstrations, Deasy and Quinn concluded that the apparently limited success of such efforts might arise from error in the assumptions on which they are based. Accordingly, they launched a systematic investigation designed to test those assumptions by obtaining answers to the question, "Why don't Negroes adopt children?" [5]

In this investigation interviews were held with 484 Negroes living in two communities—Baltimore (161 respondents) and Washington, D.C. (323 respondents). The respondents were people who, by the usual social agency standards, would be eligible as adoptive parents: partners in intact marriages, between the ages of 25 and 50, either childless (52 percent) or with a child over 5 years of age, and living in neighborhoods that were predominantly stable economically. They were longtime residents of the cities they lived in, more than 60 percent owned their own homes, 60 percent had held their present jobs for more than 10 years. In short, these people had the outer manifestations of stability and security.

The respondents were found to have an understanding, or at least a knowledge, of adoptions and why they become necessary. The majority (89 percent) knew about the adoption work of social agencies, and, although some were articulate in their criticism, they tended to regard these agencies as the best source of adoptive babies; 88 percent knew someone who had adopted a child and, although not interested in adopting a child themselves, appeared to approve the idea of adoption.

The respondents ascribed the shortage of Negro adoption homes to agency practices: "snooping," red tape, overly stringent requirements, and long waiting periods—even though the great majority of those who knew about adoption agencies said they were doing a good job. Most of them said that their main concern about a child would be in regard to his physical health and mental history rather than his birth status, parents' social position, or mother's age at the time of his birth.

The investigators commented:

. . . it is not . . . for lack of information about adoption . . . . Our respondents think of agencies as a prime source of adoptive children and express no great fear of involvement with them. Yet there seems to be a basic lack of motivation to adopt.

. . . the reasons for this lack of motivation must lie in the values to which successful urban Negroes subscribe. Surely many of the childless respondents we saw were childless by choice. If one chooses not to have a child by the biological process, why adopt one through an agency? . . . Parenthood involves risk . . . .

. . . We know too well that to attain that state of mind that makes it possible to contemplate the future with any measure of equanimity is difficult for everyone these days—and perhaps more so for Negroes . . . . As the future becomes more trustworthy for them, let us hope that more Negroes can trust and can look to a future that includes children—either born to them or taken as their own.[5]

The same investigators later undertook a similar study in which white couples in the same cities were asked the same questions. It will be interesting to compare the results.

Are Negroes Less Interested?

None of the studies or demonstrations reviewed raised any question about the assumption that there is, as Deasy and Quinn put it, a "crashing lack of interest among Negroes in the adoption of children." [5] Nevertheless, a question should be raised: Is there really less interest in adoption among Negroes than among whites, or does the scarcity of adoptive applicants merely reflect the relatively larger number of babies available for placement and the relatively smaller number of couples in a position to adopt?

The number of nonwhite children born out of wedlock each year is half again as large as the number of white children born out of wedlock. Yet there are many times more potential adoptive parents among the white population than among the nonwhite. To begin with, the white population is about 10 times as large as the nonwhite. In addition, the white population has, on the whole, far more income annually and far more economic security than the nonwhite. In 1961, for example, nearly half the nonwhite families in the United States had incomes below $3,000 and nearly one-fourth fell below $1,500—as compared with not quite one-fifth and about one-fourteenth of the white families.

Further analysis of Bureau of the Census figures on the characteristics of the white and nonwhite population of the United States, and of Children's Bureau reports on adoption, reinforces doubts about the widespread assumption that Negro couples are, on the whole, more reluctant than white couples to adopt children.

For this analysis we are indebted to Hannah

Adams of the Division of Research, Children's Bureau. Miss Adams was hampered in her computations by lack of data from a number of States, and therefore conclusions from them must be qualified accordingly. Even so qualified, however, they call for a new look at an assumption that has been remarkably free of challenge.

She found that for the country as a whole, in 1961—if one considers only husband-wife families with heads under 45 years old—the ratio of nonrelative adoptions was 3 per 1,000 couples for all races combined and also for the white population. For Negro husband-wife families of the same age, it was 2.7, only a little lower.

When income was considered as well as family composition in the analysis, a more striking challenge to the assumption emerged. It seems reasonable to suppose that the great majority of legal adoptions occur in families with incomes over $3,000 a year. If this is so, then families with less than this amount of income ought to be excluded from the base population used in figuring the adoption ratio.

When this was done, the adoption ratio for the United States in 1961, for all races combined, rose from 3 children adopted by nonrelatives per 1,000 husband-wife families with heads under 45 to 3.5 per 1,000 such families. For white families, the ratio rose only from 3 to 3.4. But for nonwhite families it rose to 4.9.

Apparently, either those nonwhite families having higher incomes were *more* likely than white families to adopt children not related to them, or a significant number of nonwhite families with incomes under $3,000 adopted children—or possibly both.

Thus it appears that the lower proportion of two-parent families found among Negroes, and the notoriously low-income levels so prevalent in this minority group, fully account for the dearth of Negro adoptive applicants, without any need to assume different attitudes toward adoption. (It should be remembered also that we are discussing here only legal adoptions, leaving aside informal arrangements of child care which are not legalized.)

The figures are not offered as conclusive. However, even when due allowance is made for the fact that they are based on estimates, they strongly suggest that group differences in the availability of adoption as a resource for child care relate to income and family composition, rather than to differences in attitudes toward adopting. In other words, review of the evidence indicates that coordinated campaigns of public education have been disappointing because they have been based on false premises. Contrary to the frequent assumption, Negroes are *not* less interested in adopting than are whites among those in a position to adopt, nor are they less informed about adoption. Community demonstrations have been expected to cure a condition that apparently did not exist.

Educational campaigns about adoption directed at Negro populations can probably help to some extent, but they cannot be expected to correct the main problems, since they are not directed to the main problems. The test of their effectiveness will be, not whether they can raise the Negro adoption rate as high as the rate among white couples, but whether they can increase still further the amount by which it already exceeds the white rate among couples who are in a position to adopt a child.

Other Possible Approaches

The evidence reviewed does not deny the possibility that adoption rates among Negroes could be increased. It shows merely that the main problem in placing Negro children does not stem from ignorance or apathy in the Negro population, and that publicity efforts alone are not likely to solve the problem.

It becomes necessary, therefore, to look for other means of solution. The evidence suggests that these should be designed, not for bringing about change in the potential adoptive parents, but rather for bringing about change in the circumstances that, directly or indirectly, encourage or discourage adoption. We cannot here spell out what these changes should be. We can, however, indicate three possible approaches to coping with the scarcity of adoptive homes for Negro children:

1. ***To modify some adoption policies and practices*** which are criticized in a number of study reports. In the criticisms it is not always possible to separate prevailing misconceptions from actual fact. However, both Fanshel's study [4] and the one conducted by MARCH [6] (Minority Adoption Recruitment of Children's Homes) report high withdrawal rates among applicants for children and document the points at which agency practices (as of the fifties when these studies were made) appeared to alienate prospective adoptive parents. It should be added that a good many adoption agencies—including some of those whose placements were studied—have shown outstanding readiness to look critically at their own procedures and have already introduced modifications that might be expected to reduce the number of ap-

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plicants who voluntarily withdraw.[7,8] Other modifications introduced by some agencies might more accurately be called innovations—for example, subsidizing the child in an adoptive home which meets all the requirements except financial ability.

2. ***To expand resources other than adoption placement*** for children for whom adoptive homes are lacking—for example, increasing payments for foster care and developing good group care arrangements.

3. ***To modify the conditions that cause the problem***—a more potent but also a more difficult method than the other two. The large numbers of Negro babies in need of placement reflect the prevalence of lower incomes among Negroes and the high incidence of broken homes and births out of wedlock that are associated with extremely low incomes among both Negroes and whites. The prevalence of these conditions among Negroes reflects, in turn, the low status—both social and economic—of a minority group in an affluent society. Efforts are afoot to improve that status. Success in these efforts could help to reduce the amount of poverty, the proportion of broken homes, and the rate of out-of-wedlock births. In the process it could also help to reduce the discrepancy between the number of babies who need homes and the number of homes ready to receive them.

It is not necessary to wait for major changes in socioeconomic conditions before attempting to increase the number of Negro adoptive homes. On the contrary, every feasible step should be taken. However, it is probably unrealistic to expect a major increase in Negro adoption rates until major changes in socioeconomic conditions are well under way.

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The material in this article is drawn from a review of research and demonstrations concerning unmarried mothers and their children, undertaken by the Children's Bureau. The review covered only reports published before 1963 and available to the Children's Bureau. Another portion of the review, now in press, is entitled, "Health Services for Unmarried Mothers."

Whether talking about delinquency rates or school programs for the culturally deprived or desegregation or fatherless families or urban renewal, one eventually comes to the economic facts of life.

"Youth Problems: Poverty and Social Action Programs," *in* The First Five Years, 1958–1963, *Syracuse University Youth Development Center, Syracuse, N.Y., 1964.*

Sharing authority with others is an essential ingredient of . . .

THE CASEWORKER'S ROLE IN SMALL GROUP HOMES

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RESIDENTIAL treatment of emotionally disturbed children in community areas is still a comparatively new development in child placement. For some social caseworkers who but a short time ago carried a caseload primarily consisting of children in foster family homes, there is a striking change in working with children living in small group homes in the community. The Jewish Children's Bureau of Chicago has found this to be true in the care of emotionally disturbed children in small group homes. The purpose of these group homes is to give disturbed children who cannot stand the close relationships expected in a foster family home the advantages of a family and community atmosphere in a therapeutically planned residence.

In foster family care, caseworkers are expected to relate and adapt themselves to the children, their parents and relatives, foster parents, and numerous auxiliary persons—teachers, doctors, and workers from other agencies. While all these people represent influences in the life of the child, only the foster parents are accountable to the agency, and even they are not totally subject to agency discipline. While the caseworker occasionally confers with the case consultant or the psychiatric consultant, his primary responsibility is to his immediate supervisor.

When caseworkers at the Jewish Children's Bureau began placing children in residential care, a major change in their role occurred. Caseworker and supervisor were no longer an isolated entity permitting others an occasional peek at their work only when they deemed it appropriate. Now, both quantitatively and qualitatively, their intense relationships were within, not outside, the agency.

The agency's group homes consist of six residential apartment units, housed in two 3-story buildings in a middle-class residential area. Living in each apartment are six children and a married couple, called child-care counselors, who care for the children and manage the household. In addition to the apartment units, each building contains recreational space, workshop equipment, and an office; and one houses a special school staffed by a principal and several teachers. A unit administrator for each building supervises the child-care counselors and coordinates their work with the work of the various other staff members involved in the children's total treatment—teachers, recreational and psychiatric consultants, and casework therapists. However, the therapeutic efforts of the caseworkers, whose caseloads may also include children in foster family care, are supervised by the agency's casework supervisors.

Thus, in working with a child in one of the residential units, the caseworker must share the child and his therapy not only with his agency supervisor but also with the child-care counselors, the unit administrator, the psychiatric consultant, the principal and teachers of the special school, the agency's group workers, its director of professional services, and others. The caseworker must be prepared to accept

regular, consistent, and thorough evaluation of his work from all of these colleagues. Even the children become sophisticated about the program, and often, with either great glee or anxiety—depending upon the nature of his transference in therapy—a child will ask what the rest of the team thinks of the caseworker's handling of the therapy.

Shared Responsibility

While this situation has created innumerable problems, it has also created the seeds for their solution. The needs of the child remain paramount in the team's thinking. Working effectively together rests in each member's ability to interact with the other team members with forthrightness and with as little defensiveness as possible.

Norman Lourie has said that "the entire staff must be oriented in the direction of the child's treatment. They should be people who can control and regulate their own attitudes, feelings, and handling of children; who can accept casework and psychiatric concepts as they are translated for them into ideas of living; who must be able to work under casework direction as part of the team." [1]

Experience has shown, however, that we may have to amend and modify these concepts. "Casework direction," while effective in a foster family setting in a small group home, is overlaid with and complicated by "unit administrator direction," "psychiatric consultant direction," and "overall agency direction." Caseworkers and child-care staff must also be aware of and work with their attitudes and feelings toward the total team. In foster family care, the caseworker has been called the "guide for the therapeutic process." Now the "guiding" must become a common responsibility, for each member of the team has his own special role to play.

The caseworker's primary function is to carry out direct therapy with the child. In examining his own relationship to the team, his problems may appear to be insurmountable. However, his very involvement with the highly complex network and the different levels of communication and authority begins to suggest a solution.

The child-care counselors are the agency's closest link to the child, since they live with the children. However, with the development of the residential treatment program, the caseworker has moved out of the confines of his office and into the child's living situation. This means that a pair of child-care counselors in charge of six children may have six caseworkers invading the sanctity of their home, and that the caseworker cannot help but observe some of the counselors' day-to-day handling of the children.

Each casework therapist is concerned primarily with the child on his caseload. His interest in the other children in the unit is dependent on their effect on the life of his child. Therefore, his first impulse is to direct the staff to serve the best interests of his child. He comes up with many ingenious and original ideas that he feels will contribute immeasurably to the health and adjustment of this particular child. He cannot understand why his enthusiasm is not always shared by the child-care counselors. Instead, he may find himself accused of overidentifying with the child, usurping the authority of the child-care counselors, the unit administrator, the principal of the school, or even of the casework director. At first, he is shocked. He has the feeling that the child-care staff means only to frustrate him; at the same time, the child-care counselors are apt to feel that the worker has come into their home only to disrupt it.

Facts must be faced. We caseworkers do identify with the children in our caseloads. Nothing suits us better than the child's improvement. If we step on others' toes in the process, we excuse ourselves by saying that these were obstacles hindering us from serving the child's best interests. When we examine our motivations for entering and remaining in the field of child placement, we find that what has sustained us is this intense interest in "our" children and our need for them to grow and develop. We would not be effective if we did not react to any real or fancied injustice to the child.

But with time, patience, heated discussions, even some hurt feelings, we learn that the world of the apartment units does not revolve around the caseworker and his child. The isolation in which the caseworker and his supervisor operate in foster family care cannot be duplicated in residential care.

To understand and resolve the problems, communication between the various persons serving the child is vital. But how and for what purpose? We are still experimenting. Much has been written about the techniques of staff communication in residential treatment settings. But rigid formulations and rules do not always fit realities. The day-to-day job demands a flexibility on the part of each staff member that disregards neither the agency structure nor the inherent roles and rights of the other team members.

With respect to the psychological treatment of the child, direct communication between the child-care counselor and the caseworker is essential. This may

seem only simple commonsense. However, such communication does not always occur.

Let me illustrate. The caseworker who has an orally deprived child in his office may allow the child to consume two cola drinks, one package of candy, and two bags of popcorn, though suppertime is only a half hour away. This may convince the child-care counselor that the caseworker is not interested in the child's achieving a balanced diet. Seeing her carefully prepared supper refused, the counselor may discuss this with the supervisor, or even make her concern evident to the child.

Or, to take another example, a child-care counselor, eager to support a child's ego, may tell a visiting parent how well he has done in school. The caseworker may feel that the best interests of the child require a minimum of communication between parent and child-care counselor and may mention this to the unit administrator. Some caseworkers believe that in such situations all problems should be filtered through the unit administrator, who then becomes a two-way street for information, ideas, and complaints. I do not believe this is a sound policy. It tends to create antagonists rather than collaborators. Only when the child-care counselor and the caseworker can communicate directly with each other, share ideas, and vent their grievances can they achieve a healthy, nondefensive, and rewarding experience.

Rewards of Communication

This does not negate the role of the unit administrator. Rather than act as a buffer or as a filter of ideas, the unit administrator can help the therapist and child-care counselor delineate and then fuse their ideas into the most meaningful experience for the child concomitant with the most effective management of the unit.

If the therapist can work effectively with the unit administrator and child-care staff, he will receive many rewards:

1. He will develop a new awareness of the problems and functioning in the residential unit as a whole. He will find that a unit geared to the needs of all the children it contains will create an atmosphere and a living experience for his child nearer to the conditions children face in normal living situations. At the same time, the child-care counselor will find that he can tolerate deviations in a child's behavior if he understands why they must be allowed. For example, if told that allowing a particular child to swear may alleviate his stuttering, the counselor may learn to tolerate the swearing, particularly if he realizes that allowing one child to swear need not prevent the child-care staff from prohibiting such language among children who are freer in acting out their aggressive feelings.

2. The therapist will develop a greater awareness of overall agency problems and needs. He will not fall into the trap of taking sides with a child who is denied an extra 10 cents for lunch or told that he may not bring a frog into the building. It does not help the child to feel that his therapist is either omnipotent or subject to the same overwhelming frustrating forces that he feels in himself.

3. The therapist will learn that he has a distinct and separate role. While each may try, neither the child-care counselor nor the therapist will be able to make up to the child completely for the true parental figures who could not meet his needs. An apartment unit with six unrelated children and surrogate parents hardly makes "a family" although it carries out certain family functions. Much less is the therapist a substitute for the child's family.

There are certain functions which a therapist should not usually assume, if he wishes the child to have a corrective experience. Without the consent of the counselor, he should not take the child shopping for clothes, pack his bags for a camping trip, or buy him a stick of bubble gum to take back to the apartment. In the social worker's need to "give" to deprived children, the casework therapist often finds himself not only in the role of an overprotective and indulgent parent but also in conflict with the external treatment goals in day-to-day living. When the caseworker makes it clear that he understands that the responsibility for the child's day-by-day care lies with the child-care counselor, the latter will gain a better understanding of the caseworker's role as therapist and of the unique meaning to the child of the therapist's office, where for an hour he may be permitted to regress, to indulge himself, and even to some degree to act out his aggressions.

Problems of Authority

Within the apartment units, the therapist finds that he becomes involved with the question of authority. Every member of the team is on a different authoritative level. Problems arise when there is an overlapping in the decision-making prerogative. At times, decisions must be made by individual team members immediately involved in a situation with

no opportunity to consult with other team members who ordinarily would have the major decision-making power.

Thus, occasionally, the therapist may have to perform a function more appropriate to a number of the resident staff; the child-care staff must make what is ostensibly a casework decision; or the unit administrator may have to make decisions more appropriately the responsibility of either the caseworker or the child-care counselor.

Rarely do such role exchanges do any irreparable damage. More often than not, the decision made is a correct one. Each such occurrence leads to intensive staff discussion of the child's total situation and of each member's separate role in meeting his needs, and finally to a greater understanding of the child's needs and his methods of handling his problems. This personal experience of staff communication in relation to day-to-day problems has proven more effective in creating real teamwork than numerous formal staff meetings called to delineate everyone's role. In such formal meetings the child is often ignored. However, such "integration meetings"—as they are called in our agency—do provide a valuable opportunity for staff members to air their feelings and to gain perspective on each others' part in achieving the agency's goals.

The Unifying Process

The agency's psychiatric consultants are actively and intensively involved in what goes on in the apartment units. They are not deskbound any more than the caseworker; nor is their knowledge of the child based only on the caseworker's written reports. As teachers, they are most effective when they see the total diagnostic and environmental picture.

All members of the team have certain vested interests beyond their total dedication to the mental health of the child. The unit administrator is interested in developing the fullest potential of the child-care counselors and will come to their support when necessary. The school principal is interested in his teachers and in helping them impart knowledge to the child. The casework therapist has a vested interest in the particular child with whom he is carrying on therapy. The vested interest of the psychiatric consultant, on the other hand, is in every member of the team. His unique skill lies in blending the therapy with the day-to-day living situation and in helping in the total unifying process.

As I have already mentioned, the child is helped most effectively when team members have an opportunity to air their differences and feelings to each other. In the "integration meetings" which are led by the psychiatrist, suddenly all the various, diffuse, separate, and sometimes apparently unrelated feelings of the team jell and form a cohesive whole. A pattern emerges, and the direction for ongoing therapeutic goals takes shape.

In Summary

Thus, in his role as therapist in a residential unit, the caseworker must not only take on added responsibilities but he also must be ready to give up, or share, some of the decision-making powers that he has in working with children in foster family care.

The caseworker must remember that his communication with other staff members must always serve a definite purpose in the therapeutic goals for the child. It does this best when it is direct rather than when it is filtered through the unit administrator. But the unit administrator plays an important role in helping the caseworker and child-care counselors gain perspective on specific problems.

While caseworkers tend to over-identify with a child, they should acknowledge this tendency without apology. Experience shows that, with this intense interest in the child, the therapist's awareness of the milieu heightens and he becomes able to work more effectively with the child-care counselors.

Finally, while authoritative roles may be carefully defined, rigid application stultifies treatment. Experience has shown that, in less time than we have thought possible, a conscious effort by all team members to impart information and to respect and trust each other makes for less concern over *who* has made decisions that affect the child in his day-to-day living or in his therapy, than over the *effect* of these decisions on the child's emotional growth.

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[1] Lourie, Norman V.: The children's institution: one step in casework treatment. *The Jewish Social Service Quarterly*, Winter 1954.

I. Strengthening Family Life

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CHILDREN deprived—physically, emotionally, educationally; children rejected; children battered and abused: these are the children who today are desperately in need of "extra" service. Intensive help from the caseworker-homemaker team is essential if these children are to survive, and, beyond this, become adequate and understanding citizens of tomorrow.

Over 50 years ago, the White House Conference on the Care of Dependent Children stated: "Home life is the highest and finest product of civilization. It is the great molding force of mind and of character, and children should not be deprived of it, except for urgent and compelling reasons." [1]

This is still the foundation of thinking in the child welfare field and it remains the broad base of all protective services to families in which children have not been receiving the care they need. Today, in "reaching out" and offering casework help which is not requested and which is sometimes not even understood, we work with parents with the aim first of helping them to understand their problems, and then of strengthening, supplementing, and supporting their efforts to improve conditions for themselves and their children to a point where they meet at least the minimum standards of the community—thus making it possible for the children to remain in their own homes.[2]

In St. Louis County (Mo.), the public child welfare caseload has been averaging some 1,300 children per month—more than half of whom receive protective service in specialized caseloads containing from 28 to 33 families. Over the years, as outside demands on families have become much greater, with stresses consequently intensified, we have been servicing an increasing number of families who need help desperately; families whose problems are serious, of long standing, and consequently overwhelming; families in which the parents are immature, inadequate as parents, mentally ill or limited, and unable to cope with their ever-present day-to-day problems. With increasing frequency, we find that by the time these families become known to us their problems have been aggravated by repeated parental failures due to physical, economic, marital, and emotional problems.

As Beulah Compton has pointed out, "the emotional . . . development of children, still the prime function of the family, is the most complicated for parents to understand and cope with." [3] This is all the more true when family life is complicated by parental failure and by the fact that the family's undesirable emotional climate—with resultant emotional damage to the children—is of long standing, and has developed to a crisis stage. The entanglement of the parents' inadequacies with the unacceptable behavior of their sick children makes it very difficult to begin service and be of real help.

It follows, then, that the agency's concern for the welfare of children must necessarily be reflected in expanded, more flexible service: service far beyond what a caseworker, carrying a full load of complex, involved, multiproblem families, can pos-

This article and the one which follows are based on papers presented at the National Conference on Homemaker Services, held in Washington, D.C., April 29–May 1, 1964.

sibly offer through brief visits to the family once, or even twice, a week; service which is imaginative, and derived from an ability to improvise and to cope with whatever one finds, whether poor housing, lack of food, lack of essential facilities, or the more difficult factors of parental immaturity, irresponsibility, indifference, and perhaps hostility, or serious physical illnesses and disabilities, mental illness, or mental limitations within the family group.

When giving protective service, one must sort out and weigh all these factors in relation to their effect primarily on the children. The question is, "How does one begin to cope with these long-entrenched problems?" and, more essentially, "How does one motivate and involve the parents to begin to help themselves and their children?"

The Caseworker-Homemaker Team

Obviously, the team approach of caseworker-homemaker is one workable answer, with homemaker service offered, and used, as an adjunct and supplementary service to protective casework.

A well-selected and supervised homemaker may in many family situations, fill the need for a substitute parent—a warm, accepting "other" adult who can be a benign maternal figure for the child and his immature parents. Being a part of the family interaction—8, 10, 12 hours a day, and at regularly scheduled intervals each week—the homemaker can help organize the household; wash and iron, to make it possible for the children to attend school; even wake them, give them a warm breakfast, and see that they make the school bus. She can mend clothes for the children, teach teenagers how to make their own clothes, and help mothers learn better household management.

But far beyond this, the homemaker can appraise the situation as it really is; understand what the family considers its most pressing problem and what its members feel they can do about it; and observe what, in fact, goes on. This factual information, colored with the sometimes intense feelings of the parents and overlayed with the homemaker's reactions and feelings, can be shared in conference with the caseworker, whose training, insight, and understanding of human behavior permits her, with her own knowledge of the situation, to make the casework decision essential to action and eventual improvement in the home.

In the caseworker-homemaker team, caseworkers and homemakers alike must assimilate certain convictions basic to the philosophy of protective services and make them an integral part of their skills. If they are to do an effective job, both must be convinced that—

1. Most people have an innate capacity to be good parents and really want to be adequate.

2. There is an "inner core of positives" or strengths in each person.

3. Parents do have the capacity to change.[2]

4. Parenthood is a privilege and can be a satisfying experience.

5. Children need mature, warm, and understanding parents.

6. Through well-timed interest and challenge, parents can often use help given by the worker and homemaker and so begin to improve the care of their children.

7. The triad of worker-homemaker-parent is the most important tool in protective casework services—the closer the team and the family agree on what is needed and wanted, the more strength there is upon which to build.

The Homemakers

In our agency, homemaker service began nearly 7 years ago as a demonstration unit with two homemakers. We now have three full-time homemakers, but see the need for many more. Yet, even with this limited staff, imaginative scheduling has made it possible to give a surprising amount of service. Since the program's inception, we have given homemaker service to 330 different families, involving 869 children. In the past year, we have served, per month, an average of 27 families, involving 106 children.

Our homemakers have been recruited from a number of sources: referrals from our own public assistance workers; persons suggested after interpretation of this program to the child welfare advisory committee or to civic groups in the community; responses to newspaper ads.

In recruiting homemakers, we look for friendly, enthusiastic women who show a real interest in people and their problems. We want, preferably, married women who have raised their own children, thus having some background of experience in family living.

Our homemakers' formal education has ranged from sixth grade to 1 year of college. A hard-and-fast educational requirement seems unnecessary. More important are interest, eagerness to learn, patience, and tolerance of others' failings.

In our preliminary training, we have given the

homemakers a general orientation to the agency, including an introduction to the functions of the child welfare staff and to the homemakers' functions as part of "the casework team." Further orientation has included consideration of nutrition, household budgeting, and the meaning of food in relation to personal attitudes and cultural patterns; some discussion of normal child development—the care and behavior of babies, preschool children, school-age children, and adolescents; and some consideration of the relationship of the homemaker to an ill person, to parents, and to physically handicapped, emotionally disturbed, or mentally retarded children.

Additional training occurs on the job. This has involved the participation of the homemaker in case conferences about special problems, sometimes including persons outside the agency, such as the nutritionist from the St. Louis County Public Health Department. These conferences have proved invaluable in helping the homemakers understand and cope with different kinds of complicated situations. The homemakers have also participated in child-guidance clinic case conferences when a child they know is under discussion, thereby not only deepening their own understanding of the child but also, through their own observations of interactions in the home, contributing to the understanding of the professional staff. Occasionally, the homemakers have attended community workshops on child development and behavior and other appropriate subjects.

Our homemakers are covered under county civil service, have salaries on a five-step pay range, and have working hours, sick leave, and vacation time comparable to the social caseworkers.

The homemaker supervisor, a social worker, provides the homemakers with close supervision and constant interpretation. She provides a kind of liaison between the evaluation and plans of the family's caseworker (a child welfare worker) and the homemaker's activities and observations. The close working relationship between homemaker supervisor, child welfare worker, and homemaker imbues the homemaker with the conviction that, in her observation and individualization of the family members, her stimulation and motivation of the parents, and her ability to accept situations and families as they are, she is truly a member of a "team" strengthening family life. We have found that the homemaker needs continuing support, interpretation, and guidance to relate well to all members of a family without becoming personally overinvolved; and to maintain her own equilibrium in the midst of strained family relationships, the children's testing her out, and the emotional upsets of ill mothers and overburdened fathers.

"In recruiting homemakers, we look for friendly, enthusiastic women who show a real interest in people and their problems."

With so few homemakers available (because of a shortage of funds), our agency has developed its own brand of imaginative scheduling and shuffling of homemaker assignments. Obviously, long-term placements are not possible, yet regular scheduling of certain days per week for consecutive weeks—and even months, if the situation warrants—is possible, and has, on the whole, seemed to meet the special needs of many families.

For example:

The members of a motherless family of eight children have tried hard, since the death of the mother, to accept a lonesome, insecure, and very dependent father who—when times become difficult—leans upon alcohol. Strong attachments and strengths in this home suggest that protective casework service—with the close help of a homemaker—may hold the home together for these children, and may begin to encourage the family to provide a better, more acceptable standard of living.

The homemaker goes into this home two to three times a week—from 3 to 6 p. m., after the children return from school. She goes particularly for the purpose of teaching the oldest girl, Mary, age 15, menu planning, cooking, and good housekeeping standards. Homemaking responsibilities for such a large, disorganized household seem far too much for Mary to handle alone, and she desperately needs the close support of both homemaker and caseworker.

* * *

After the death of her husband, 6 years ago, a mother of

three school-age children lost interest in herself, her home, and her children. Her housekeeping standards became progressively worse. She appeared depressed, withdrawn, and at times out of touch with reality, and she was unable to make any plans for her family. She seemed to be living in the past and made no effort to form any relationships in the present.

With the concerted effort of both homemaker and caseworker, this mother has occasionally "come out of herself" enough to work along with the homemaker in housecleaning, sorting out mounds of trash, discussing needed major repairs to the house, and even, with the homemaker's help, making curtains. The homemaker has tried not only to bring about enough improvement in the home to assure reasonable standards of health and comfort for the children, but also—through her observations—to help the caseworker evaluate the real capacity of the mother for caring for her family.

* * *

A very young emotionally disturbed mother of three preschool children, with no husband in the home, has been almost immobilized by the difficulties of managing on a meager public assistance grant. A visit from a homemaker for part of a day twice a week not only helps her get caught up on her housework and laundry, but also gives her a chance to take the children on an outing, to have them taken to the clinic, to call for and learn to use surplus foods, and sometimes just to get off by herself for a while. With the caseworker's help and the steady support of the warm, easygoing homemaker, this mother is becoming less depressed, is learning to manage better, and is beginning to give the children a little much-needed individual attention.

Since "every unhappy family is unhappy in its own way,"[4] how the caseworker-homemaker team functions in each family where children have been neglected or abused must be an individual casework decision. But more teamwork of this nature is necessary if the individual and complex patterns of family unhappiness, which have such devastating repercussions on children, are to be understood and alleviated.

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[1] 60th Cong., 2d sess., U.S. Senate: Proceedings of the White House Conference on the Care of Dependent Children, held in Washington, D.C., Jan. 25–26, 1909. *In* Senate documents, vol. xiii, 60th Cong., 2d sess. Washington, D.C. 1909.

[2] Scherer, Lorena: Protective casework service. *Children*, January–February 1956.

[3] Compton, Beulah: Services to neglected children in their own homes. Presented at institute given for child welfare services staff development at meeting of Missouri Division of Welfare, St. Louis. Feb. 27–28, 1962.

[4] Tolstoy, Leo: "Anna Karenina."

HOMEMAKER SERVICE IN NEGLECT AND ABUSE

II. A Tool for Case Evaluation

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THE GENERAL PUBLIC, and even professional persons, find it difficult to believe that a parent will willfully and intentionally harm his child. Yet, not long ago, the New York papers carried headlines about a 7-year-old crippled child who was beaten to death by her mother and the mother's "boy friend" solely because "we enjoy beating her." Such incidents are not unusual, and have in recent years become the subject of nationwide concern.

As Elizabeth Elmer has said, there are ". . . unbelievably primitive transactions that take place beyond our gaze, safe from our curious questions."[1] These acts range from battering a child in impulsive rage to deliberate intent to murder. In such situations, the use of homemaker service to assist a social caseworker in the evaluation of family strengths and weaknesses, and to provide facts based on direct observation, can be invaluable in helping a responsible agency to take appropriate action for the protection of the child.

The value of the homemaker's role in clarification of the vague and uneasy impressions of hospitals and social agencies that there is need for intervention has been shown in many cases. Sometimes the homemaker has been the only source through which the actual facts have become known, enabling an agency to take court action.

Obviously, homemaker service is a resource which could be used increasingly by all communities to obtain a clearer picture of family relationships and incidents taking place in the home. Necessary action to protect children who are in danger has all too long been hampered by "the maze of contradictory statements and lack of real facts which so often surround cases of seriously neglected or battered children." [2]

This is illustrated in the case of Paul, age 9 months, who will never walk, and who has had four hospital admissions for injuries in his few short months of life. Yet he has been sent home again and again to become the repeated object of his father's rage and violence. Even when his father acknowledged the acts that resulted in Paul's becoming a hopeless cripple, the legal, medical, and social professions were reluctant to heed this family's unspoken appeal for Paul's protection.

Both Paul's parents are deaf-mutes. His father's history is full of evidence of frustration and rage over his inability to communicate and compete on a level with others. The parents met as adolescents on a social outing and were married after pregnancy with their first child occurred.

Although the father had occasional explosions of temper, he seems to have managed to sustain himself and his family without untoward incident until the conception of the second child, Paul. He then became so depressed that he lost control of his actions. This continued after Paul's birth, and worsened when Paul's mother proved to be totally unable to manage the two babies, less than a year apart in age. The father gave up his job and accepted public aid in order to remain at home to help his wife.

Outwardly, Paul's father seemed to be elated with the new baby, rocking him, kissing him, and holding him very tight. However, only 1 month after his birth, Paul was admitted to the hospital with a fractured skull. The parents reported he had been screaming and crying, and that his father, who was holding him at the time, accidently dropped him on his head. Even before this, Paul had been treated for fractures, though not hospitalized.

Paul was treated and sent home only to be readmitted to the hospital at the age of 4 months, so badly beaten and bruised that he developed a spastic condition of both legs which will prevent him from ever walking. His father, who brought Paul to the hospital, admitted that the injuries occurred when he punched the baby in the abdomen.

At that point, the hospital reported the matter to the authorities. The father was arrested and admitted to a hospital prison ward, where he remained for a month. He was then released on bail and returned home. His trial was postponed and later dismissed.

The point was made in a recent issue of CHILDREN that parents who neglect and batter their children are actually expressing their parental incapacities in action, and are asking to be stopped in their brutal behavior. Why else do they bring their injured children to hospitals, thus running a high risk of punishment? [2]

This was certainly true in the case of Paul's father, who asked for readmission to the hospital for himself because of depression and self-hate, which he admitted he displaced on the baby. However, he was diagnosed "not actively psychotic" and was released.

When Paul was sufficiently recovered to leave the hospital, he was once again discharged and taken home. This decision was made on the basis of his father's diagnosis, and because both parents had agreed to seek psychiatric help, along with social service and homemaker service.

Enter a Homemaker

By this time, several community agencies were interested in the family—the hospital, a psychiatric clinic, the family court, and the public welfare department. On a purchase-of-service agreement with the public agency, the Children's Aid Society, a voluntary agency, placed a homemaker with the family; she remained for 6 weeks.

The homemaker's observations proved invaluable in enabling the various interested agencies to obtain a clear picture of the family relationships, and to conclude that, without question, the child was in constant danger as long as he remained with his father.

The homemaker graphically described the father's handling of the baby: overfeeding him; hugging and kissing him so roughly that the baby often cried; shaking him violently when he did cry; giving him the bottle so forcefully that blisters were raised on his mouth.

The mother communicated with the homemaker by note and told her that the father stayed up late to watch television and that she was afraid to go to bed before he did because he might harm his son. On the other hand, the mother was unable to bring herself to make a formal complaint against the father.

Paul's parents did not follow through on the psychiatric referral. Therefore, on the basis of the homemaker's observations, a consultation between the children's agency providing homemaker service and the referring agency resulted in a decision to appeal to the court for the baby's permanent removal.

Later that same day, Paul was readmitted to the hospital suffering from a brain concussion. He had been dropped on his head by his father when he started crying during a feeding.

The case was referred to the family court and is still in process of investigation. Paul is in the custody of the court, pending decision.

Other Cases

The unique value of homemaker service in case evaluation, and even in casefinding, is illustrated in other family situations posing danger to children.

Such an example is the Grey family, with five children, age 5 and under. This family was referred to a protective agency by the pediatric clinic of a hospital because of the physical condition of the youngest child.

The homemaker—on 8-hour-a-day, 5-day-a-week assignment—learned that Mr. Grey, in his early thirties, had formerly been a compulsive drinker given to abusing his wife and family when drunk. He had joined Alcoholics Anonymous, and turned to this organization for his outside contacts, going from its meetings directly to his night job. He came home about 9 a.m., and slept most of the day, leaving Mrs. Grey to care for the children day and night on her own.

Her method of retaliation was to lock the children in the bedroom, so that they could not wander away. Often the homemaker would arrive in the morning to find the mother still in bed, and the locked-in children's physical needs completely unattended.

After 4 months, psychiatric consultation was scheduled. The psychiatrist felt that both parents were probably psychotic. The father was regarded as posing more danger to the children than the mother. His need to feel omnipotent was seen as the cause of his rages, during which he beat his wife and children.

The protective agency strongly urged court action to remove the children from the home.

Often the factor which precipitates a referral for homemaker service is one which is incidental to the total problem mosaic of the family, and extended observation and evaluation are needed. This is illustrated by the "Rivera case," which, after a year of homemaker service, still requires additional observations and tests before a suitable therapeutic plan can be made.

The Rivera parents are in their early twenties, their four children ranging in age from 4 years to a few months. Homemaker service was first provided to enable Mrs. Rivera to keep medical appointments at the center for her two younger children. She was unable to manage taking all four children to the clinic by herself.

The homemaker's observations made it immediately apparent that the family's problems were much greater and more complicated than they were originally thought to be. The mother alternated screaming at the children with bribing them to be good. She readily acknowledged that she had no control over them, and stated that both she and her husband wanted to place them in foster care so that they might work to pay off their debts. On the basis of these and other early impressions, full-time homemaker service was offered the family to help relieve immediate pressures and make possible further evaluation.

"A . . . homemaker can . . . help many neglecting parents by . . . direct teaching by demonstration and example . . . ."

Soon after full-time homemaker service began, it became that the situation was seriously complicated by the behavior of the 3-year-old child, described by his mother as having been "nothing but trouble" from birth. He was hyperactive, given to severe temper tantrums without apparent cause, enuretic, day and night, and was eating dirt, wood, and plaster. The parents agreed to a psychiatric evaluation of this child, which resulted in a tentative diagnosis of childhood psychosis with homicidal and suicidal tendencies. Hospitalization of the child, though urgently needed, was delayed owing to lack of inpatient psychiatric facilities for a child of 3.

Meanwhile, the home situation had worsened. The mother began to clean the house compulsively, sweeping the floors several times a day, washing the kitchen floor before lunch and again after lunch, and changing the children's clothing two or three times a day. Her moods alternated between silence and excessive talking.

She almost totally ignored the children, except to scream at them, push them, or hit them if they got in the way of her cleaning. If the homemaker had not been present, the mother would have let the children harm themselves, or each other, by her neglect. Two of the other children began to imitate the 3-year-old's tantrums and plaster eating.

On one occasion the mother became so enraged at a tantrum of the oldest child, a girl, that she took off her shoe and beat the child until the homemaker intervened. Later that day the mother said that she might have beaten the child to death, had it not been for the homemaker. She made numerous references to children's deaths.

The psychiatrist's opinion is that this mother is either psychotic or reacting with abnormal behavior to the strain of the 3-year-old's behavior. A true

assessment cannot be made until this child is removed. Short- or long-term placement of all of the children may be indicated.

A Grave Responsibility

We have been a long time in acting on the child welfare principle that children have an inherent right to the kind of care and nurturing that will enable them to grow up into healthy adults who will be able to give adequate care to their own children. The first step in such a procedure, and one which is immediately demanded by the uncovering of an alarming number of children in need of protection, is to find ways of obtaining the facts and acting quickly to protect those children whose lives are in danger. Helen Boardman has warned:

> . . . Experiences with the repetitive nature of injuries indicate that an adult who has once injured a child is likely to repeat. Police warnings, court action, and probationary status have not been adequate deterrents. *The child must be considered to be in grave danger unless his environment can be proved to be safe.* The adult, too, needs protection from the consequences of his own explosive behavior.[3]

Yet, from the legal point of view:

> The right of the parents to the care and custody of their children creates a strong presumption in favor of the parents in any proceedings to remove the child. Judicial decisions indicate that the conduct of the parents must amount to *forfeiture* or *abandonment* of their right to custody. . . .
>
> In the face of these rights, it is obvious that any petition requesting removal of a child from his family must be based on solid and substantial reasons, established by plain and certain proofs of the neglect. The rights of parents are protected by tradition and precedent, and vague or ambiguous allegations will not be sufficient to show that the parent has forfeited these rights.[4]

Obviously, there is a need for clarification, early identification of the problem, and active steps toward a solution.

Immediate authoritative action is needed in some instances to protect the life of the child in danger. In other instances, parents can be helped by a professional caseworker and a homemaker working in combination to achieve more healthy family relationships and to adopt better methods of child care, as the preceding article by Louise Foresman makes clear. A homemaker can also help many neglecting parents by the direct teaching by demonstration and example which is so clearly in the homemaker's province. The placement of a homemaker, along with the services of the caseworker, can be invaluable in obtaining a well-rounded picture of the family dynamics and of the parents' actual or potential readiness to use help.

As has already been pointed out in CHILDREN,[2] many types of services are needed in combination to protect children from neglect and abuse. Homemaker service should be in the forefront of these. Morris and Gould have found that "services constructively engaging parents into society and putting them in contact with those who exercise nurturing parental roles are most effective in protecting children and in promoting social public health." [5]

Most important is the necessity of establishing the facts early in the child's life, not only to preserve his life but to use whatever forms of intervention can and should be used to alter the course when physical and personality damage is being inflicted.

Services must be provided long before the child enters school, for, by that time, it is often too late and the damage is often irreversible.

If we are to prevent the development of the kinds of personalities which can murder a President or, without reasonable provocation, murder his murderer, *we must reach these personalities before the mold is set.*

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[1] Elmer, Elizabeth: Abused young children seen in hospitals. *Social Work,* October 1960.

[2] Morris, Marian G.; Gould, Robert W.; Matthews, Patricia J.: Toward prevention of child abuse. *Children,* March–April 1964.

[3] Boardman, Helen E.: A project to rescue children from inflicted injuries. *Social Work,* January 1962.

[4] Downs, William T.: The meaning and handling of child neglect—a legal view. *Child Welfare,* March 1963.

[5] Morris, Marian G.; Gould, Robert W.: Role reversal: A concept in dealing with the neglected battered-child syndrome. *In* The neglected battered-child syndrome; role reversal in parents. Child Welfare League of America, New York. 1963.

. . . have you ever wondered how many fine scientists, doctors, musicians, authors, astronauts or spiritual leaders may have been lost to us because a child was neglected?

Esther Peterson, Assistant Secretary of Labor, at a meeting of the chairmen of the State day-care advisory committees, March 19, 1964.

BOOK NOTES

YOUTH ON THE STREETS: work with alienated youth groups. Saul Bernstein. Association Press, New York. 1964. 160 pp. $3.95.

"A thesis of this book," writes the author, "is that the gap has become alarmingly great between youth at the bottom, the sub-lower class, and the respectable adult community, so great that it threatens to become the most important domestic problem in the United States." The book, an outgrowth of a study of work with youth gangs, deals with the causes and treatment of their alienation from society. Its author is professor and head of the group work department at Boston University School of Social Work.

Professor Bernstein gathered his material in nine major cities: Boston, Chicago, Cleveland, Detroit, Los Angeles, New York, Philadelphia, San Francisco, and Washington. He interviewed streetworkers, their supervisors and executives, judges, police officials, probation officers, psychiatrists, school officials, and researchers. He talked with members of street gangs and with some of the youths' parents.

How successful have social agencies been with these youngsters? In the area of private behavior—especially in relation to sex, drugs, drinking—while the responses were "far from completely negative," the author reports, "they were mostly discouraging." In the areas related to school and job, there were many examples of success, but, he says, not nearly enough.

The author concludes that the key role in working with delinquents is held by the streetworker, who faces "the challenge of helping to provide satisfactory substitutes for the excitement of fighting, stealing, and vandalism."

The author recommends that social agencies make a greater commitment to work with the poor, that streetworkers receive more professional training, that mass media tell the story to the public, that public officials respond more to the problem, and that more money be invested in combating it. However, he maintains that only the whole community can remove the economic and social roadblocks to normal, healthy lives for these youngsters.

THE DEAF CHILD. Edith Whetnall and D. B. Fry. Charles C Thomas, Springfield, Ill. 1964. 237 pp. $8.50.

This book is based on the principles and practice of the Audiology Unit of the Royal National Throat, Nose, and Ear Hospital and the Institute of Laryngology and Otology in the University of London.

The central theme is "the auditory approach to the training of deaf children," as developed at the unit since it began as the "Deafness Aid Clinic" in 1947. This approach, according to the authors, "depends on understanding the part played by the cerebral cortex in learning the associated skills of hearing and speech." The subject is approached from the viewpoints of both experimental phonetics and clinical otology.

The book was written primarily for doctors—otologists, pediatricians, health officers, and general practitioners. But the authors state that they hope "it may also be of value to child psychologists, hearing and speech therapists, and teachers of the deaf."

CHALLENGES IN MENTAL RETARDATION. Gunnar Dybwad. Foreword by Leonard Mayo. Columbia University Press, New York. 1964. 287 pp. $6.

Among other subjects considered in this collection of writings by the former executive director of the National Association for Retarded Children are: the early education of the handicapped child, the family's role in caring for the mentally retarded, children and adults in residential care, the mentally retarded children who become delinquent, the rehabilitation of adult retardates, and community organization for the mentally retarded. An appendix by Rosemary Dybwad describes the development of parent-sponsored associations for mentally retarded children in other countries.

Dr. Dybwad maintains that no community in this country offers a well-rounded and quantitatively adequate program for the retarded.

He also maintains that of the billion dollars spent by all sources on the retarded, a disproportionate amount is spent on the 4 percent in institutions. Nevertheless, he points out, practically all States have long institutional waiting lists and the 150,000 available institutional beds are not nearly enough.

"Speaking quantitatively and qualitatively," Dr. Dybwad states, "no other service has as much to offer to the total group of mentally retarded as has the public school system." Of the million mentally retarded children in need of special programs in the public schools, only about one-fifth are receiving such instruction, he maintains.

Stressing the importance of vocational training for the mentally retarded and of opportunities to develop self-reliance, Dr. Dybwad cites the workshops of the retarded in Holland as examples to be emulated.

"The key problem confronting parents of mentally retarded children is the need for competent diagnostic services," Dr. Dybwad maintains, and he stresses the importance of observing functional performance in clinical evaluation and re-evaluation of the child.

Research in Europe and the United States shows that severely as well as mildly retarded children have a distinct growth potential, he points out.

THE JOY OF CHILDREN. Text by Pearl S. Buck, with an introduction by Roy Sorenson, chairman of the National Committee for Children and Youth. The John Day Co., New York. 1964. 211 pp. Also for sale from the National Committee for Children and Youth, 1145 19th Street NW., Washington, D.C., 20036. $7.50.

This volume is based on the photographic exhibit, "These Are Our Children," which was assembled by the Eastman Kodak Co. for the 1960 White House Conference on Children and Youth.

Divided into groups with chapter headings such as "For Every Child—Protection and Care; Security and Love," the 247 pictures and accompanying text portray not only the joys but also the sorrows and conflicts of childhood, adolescence, and early adulthood.

Some impressions of the 1964 meeting of the International Conference on Social Work

SOCIAL PROGRESS THROUGH SOCIAL PLANNING

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SOCIAL PLANNING was the 1964 "hit theme" in the international arena. UNICEF held a significant conference on "The Needs of Children and National Planning" in Bellagio, Italy, in April; United Nations agencies gave increased attention and technical assistance to national planning bodies in the developing countries; and the U.S. Agency for International Development gave evidence of increased awareness that our own foreign aid program must coordinate closely with a recipient country's planning efforts. It was timely, therefore, for the 12th International Conference on Social Work, meeting in Athens, Greece, in September 1964, to tackle the problem of planning, and it did so under the Conference theme: "Social Progress Through Social Planning—The Role of Social Work."

Sixty-six nations were represented at the Conference by 2,300 delegates. The United States had more than 400 delegates in attendance; more than 50 delegates came from faraway Japan; and Latin America was well represented, with Brazil alone having more than 60. Practically every Western European country had substantial delegations and the Communist-bloc nations were represented by delegations from Yugoslavia, Czechoslovakia, and Poland. The developing countries of Asia and Africa were also represented.

Twenty-eight countries submitted "national reports" of activities in their own countries relating to the Conference theme; country case histories on planning activities were presented; internationally known experts delivered provocative papers; and some 40 study groups and commissions provided forums for intensive discussion.

The significance of such a Conference for the United States and for its children is, of course, difficult to assess. However, we are increasingly aware that in this shrinking world, ideas know no boundaries. International meetings create an "international vocabulary," open up channels of communication between professional personnel of the various countries represented, and through such means have a direct and indirect influence on all countries.

Dominating Notes

It is difficult to summarize briefly the hundreds of papers, reports, and sessions of the conference which bore on the planning theme. However, several notes dominated:

1. The growth of the "planning idea" has made *national* planning an important factor in the lives of people throughout the world. Widely recognized at the Conference, this assumption was spelled out in the report submitted by Pakistan: "There seems to be no escape from planning today. We hear of all kinds of planning: international planning; national planning; state planning; regional planning; area planning; local planning; space planning; economic planning; physical planning; social planning; integrated or comprehensive planning; sectoral planning; community planning; and even the all-important, though controversial, family planning. Planning can be undertaken at all levels: local, state, or provincial, and national. Again, it can be undertaken both in the private sector and in the public sector."

2. In countries which do not have national planning boards or commissions, such as the United States and Germany, the rapidity of social change has necessitated long-range sectoral planning by the various agencies charged with responsibility for specific programs such as health, education, and agriculture.

3. National planning in most countries has emphasized economic goals. The developing countries, particularly, have concentrated on economic development and growth, increased production, a higher gross national product, and the like. Social factors have frequently been ignored until they have become serious problems.

4. Social planning must be integrated with economic planning, in order to prevent or mitigate many of the social problems which arise in both industrialized and industrializing countries, in both highly developed and still-developing countries.

5. More attention must be given by persons working in the social field to quantifying social needs, so that planners can assess costs and impact on the economy, and make judgments as to priorities.

6. In every country, priorities in so-

cial goals must be established. This is, of course, more important in less developed nations where resources are limited.

7. Social planning is influenced or controlled by the political structure and organization of the individual country. It was pointed out that although scientific developments may have a certain independence from the structure of the society in which they take place—for example, a moonshot can be developed by nations with diametrically opposed economic and political systems—social developments and programs are irrevocably tied to the structure of the country in which they take place. Thus, a country which philosophically rejects the concept of planning will approach social planning in an entirely different manner from a country which is conceived of as a completely planned economy.

8. Factual data necessary for social planning are frequently unavailable. Social research was reported to be lagging behind economic research even in highly developed countries. Stress was laid on the importance of research, not only for fact gathering but also for understanding the basic causes of the social dislocations and problems with which social planning and social welfare agencies must deal. There was agreement that a vast amount of pertinent, accurate, and systematized data is required for effective and efficient planning.

9. Today social agencies generally do not play an important role in social planning, although their knowledge of social problems would be valuable to planners and should be utilized. This was reported from countries all over the world.

10. The field of social work can make important contributions to planning because of the experience and knowledge of the persons working in this area.

11. Citizen participation in planning efforts is necessary, if such planning is to be understood and accepted. Such participation was stressed by representatives from nations differing widely in political ideology and structure. The consensus of the Conference on this point was expressed in the report from Spain: "Planning is, by its very definition, a social matter, and this fact implies participation by the public, not only in the planning itself, but also in carrying out what has been planned."

12. The growth of social planning activities necessitates the training of personnel for planning tasks.

The foregoing is an indicative rather than a complete listing of general conclusions reached at the Conference.

Dr. Ellen Winston, Commissioner of Welfare, U.S. Department of Health, Education, and Welfare, summarized the sense of the Conference well when she asserted that "the concept of development, of the deliberate ordering of resources to assure a better life, is the rallying call of our time throughout the world."

Implications for This Country

What are the implications of this Conference for the United States and particularly for the 70 million children of our country? What can we, in our prosperous and well-developed Nation, learn from this exchange of experiences with representatives of the world community of nations? Many valuable facts and ideas emerged which can be of value to those of us concerned with social problems in the United States. For example, it was made clear that—

1. The social problems we face in this country, such as juvenile delinquency, unmarried parenthood, family disorganization, migration from rural to urban areas, and others, are worldwide. Our attention, therefore, needs to be focused on fundamental causes and not only on factors indigenous to the United States.

2. The necessity of husbanding limited resources in the less affluent countries has forced these countries to study social problems in order to establish priorities. Since we in the United States are becoming increasingly concerned with the problem of priorities in goals, the experiences of priority setting and planning by other countries deserve study on our part.

3. In the scramble for a greater share of a country's resources by various groups for their special interests—schools, health agencies, businesses, roads, and others—the interests of nonvocal groups of the population, such as children, may not obtain their appropriate share. How can such interests be protected and considered in the planning of social programs? Although the experiences of many countries may not be applicable to the United States, we must be alert to any that are.

4. In rapidly developing societies, problems which are ignored can be costly and damaging. When we see the catastrophic results of lack of planning for the increase in the school population in other countries, and when we realize that the number of college students in the United States may increase by 1970 from the present 4.3 million to 7 million, we may be impressed with the importance of immediate planning. And as we examine the programs of other nations, and realize that infant mortality in this country is still higher than in the United Kingdom, Sweden, Australia, Norway, Switzerland, Denmark, and several other countries, perhaps our efforts to improve the lot of America's children may receive greater impetus.

The International Conference on Social Work in Athens revealed again the leadership of the United States in many areas. It also demonstrated that the unique and indigenous developments in other countries may contribute to our understanding of problems here and be of value in our own social programs.

Many of our social institutions have had their roots in the developments of other countries—for example, much of the pattern of our social insurances was borrowed from Germany, and our basic ideas of public assistance were inherited from the poor laws of Great Britain.

The recent meeting of the International Conference on Social Work has demonstrated that today the social developments of many countries bear promise of making contributions to the solution of many current social problems, and that we in the United States can learn from other nations as well as contribute to their social development.

Some preliminary findings of three followup studies on the . . .

EFFECTS OF ADOPTION ON CHILDREN FROM INSTITUTIONS

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THE National Institute of Mental Health is presently carrying on three followup studies of adults who were reared away from their own parents. The purpose is to determine the adult status of children previously studied by the Iowa Child Welfare Research Station, State University of Iowa, in cooperation with the Children's Division, Iowa Board of Control of State Institutions, which initiated modes of intervention in infancy or early childhood. These include followup studies of—

I. A longitudinal study of 100 adopted children.[1] The followup of this study is being carried on by the original investigators.

II. A study of the effects of differential stimulation on mentally retarded children.[2] The followup of this study is also being carried on by the original investigator.

III. A study of the mental development in adoptive homes of children whose biological mothers were mentally retarded.[3] The followup of this study is being carried on by Lowell W. Schenke, psychologist, Iowa Board of Control of State Institutions, with one of the original investigators (the writer) serving as consultant.

In all three of these studies, the children selected for study were considered to be biologically sound and without demonstrable abnormality as determined through diagnostic evaluation by competent pediatricians. With the inclusion of the present followup studies, they cover a life span of 30 years, the present ages of the subjects being within a range of 25 to 35 years.

Adopted Children

In regard to the followup of Study I, all adoptive parents and adopted children have been located after a lapse of 16 years since the last contacts of the earlier study. Interviews with adoptive parents and their adult adopted children are nearing completion. Analysis of the data will start in the near future.

Preliminary indications are that these adoptive children as adults are achieving at levels consistently higher than would have been predicted from the intellectual, educational, or socioeconomic level of the biological parents, and equal to the expectancy for children living in the homes of natural parents capable of providing environmental impacts similar to those which have been provided by the adoptive parents.

Mentally Retarded Children

In regard to followup of Study II, all subjects have been located after a lapse of 21 years, all interviews completed, with the data presently being processed.

Preliminary findings of this followup study are particularly startling. In the original study, 13 children in an experimental group, all mentally retarded at the beginning of the study, were at an early age transferred from one institution to another which provided a much higher degree of one-to-one emotional relationship between mother-surrogates and the children. Later, 11 of these children were placed in adoptive homes.

A contrast group of 12 children, initially at a higher level of intelligence than those in the experimental group, remained in a relatively nonstimulating institutional environment over a prolonged period of time. In the initial study, the children in the experimental group showed a decided increase in rate of mental growth, whereas the children in the contrast group showed progressive mental retardation.

In the adult followup study, the two groups continued to be remarkably divergent. All 13 children in the experimental group are self-supporting, and none is a ward of any institution, public or private. Eleven of the 13 children are married, and 9 of these have children.

Of the 12 children in the contrast group, 1 died in adolescence following continued residence in a State institution for the mentally retarded; 4 are still wards of institutions—1 of these is in a mental hospital, and 3 are in institutions for the mentally retarded. Among those no longer wards of institutions, only two have married, and one of these is divorced. Two of the four females in the contrast group were sterilized in late adolescence to preclude the possibility of procreation if later placed out to work.

In education, disparity between the two groups is great. In the experimental group, the median grade completed is the 12th; in the contrast group,

the 3d. Four subjects in the experimental group have had one year or more of college work, one of the boys having received a B.A. degree. Occupationally, the experimental group ranges from professional and semiprofessional positions to semiskilled labor or domestic work. In the contrast group, 50 percent of the subjects are unemployed, and those that are employed are, with the exception of one person, unskilled laborers.

One girl in the experimental group who initially had an IQ of 35 has subsequently graduated from high school and taken one semester of work at a college. She is married and has two boys. These boys have been given intelligence tests and have achieved IQ scores of 128 and 107.

If this girl had had the continuing experience characteristic of those in the contrast group, she would have remained all these years on a custodial ward in an institution for the mentally retarded, or have been sterilized in late adolescence or early adulthood and subsequently placed out on a nonskilled labor type of domestic employment.

In fact, "but for the grace of God," any one of the cases in the experimental group might have experienced the impact of deprivation of those in the contrast group, and vice versa.

Cost to the State

We are also studying the cost to the State of each subject in the experimental group and the contrast group of Study II—based on information as to per capita cost for institutional care per month or year for each of the years from 1932 to 1963. Preliminary indications are shocking.

In the experimental group the median total cost is less than $1,000, whereas in the contrast group it is 10 times that, with a range from $7,000 to $24,000. One case in the contrast group can be cited of a person who has been a ward of the State institution for over 30 years. The total cost to the State in this instance has been $24,113.

In the 1930's, the monthly per capita cost at State children's institutions and at mental hospitals ranged around $17 per month. This has progressively increased over the years until the present figure is considerably more than $200 per month. We can speculatively extrapolate on the cost to the State of the subjects in Study II had our comparisons started in 1963 instead of 1932. Assuming that costs were constant from 1963 to 1993, the case in the example cited would have cost the State $100,000.

Mentally Retarded Parents

As already mentioned, Study III involved children whose biological mothers were considered to be mentally retarded. The children had been separated from their natural mothers in early infancy, either by voluntary release or by court commitment, and had been placed in adoptive homes before they were 2 years old. The study included a total of 87 cases. IQ scores were obtained on each of the mothers, none of whom achieved higher than 75. The range extended down to an IQ of 32.

After a time interval of 21 years, efforts are under way to locate the adoptive parents and children of this study, and indications are that all or most of them will be found. Several interviews have already been completed.

In the followup, in addition to securing information on the adult status of the children, intelligence tests are being administered to the second generation—the grandchildren of the mentally retarded, biological grandmothers.

Preliminary findings in this followup study suggest that the first generation (the children of the original study) compares favorably in occupational status as adults with the Iowa population of comparable ages according to 1960 census figures. The second-generation children are scoring average and above on intelligence tests.

Some Implications

Since the preliminary findings of these three followup studies are substantiated by reports of many supporting studies published in the past 20 years, it would seem that we have adequate knowledge for designing programs of intervention to counteract the devastating effects of poverty, sociocultural deprivation, maternal deprivation, or a combination of these ills. This means making expenditures for prevention, rather than waiting for the tremendous costs of a curative nature. It does not, of course, preclude further research and exploratory studies to determine the optimum modes of intervention and the most appropriate ages for initiating such procedures.

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[1] Skodak, Marie; Skeels, Harold M.: A final follow-up study of one hundred adopted children. *Journal of Genetic Psychology*, September 1949.

[2] Skeels, Harold M.; Dye, Harold B.: A study of the effects of differential stimulation on mentally retarded children. (Proceedings and addresses of the American Association on Mental Deficiency.) *Journal of Psycho-asthenics*, vol. 44, no. 1, 1938–39.

[3] Skeels, Harold M.; Harms, Irene: Children with inferior social histories; their mental development in adoptive homes. *Journal of Genetic Psychology*, June 1948.

The discoveries being made in prevention of mental retardation and methods of bringing forth the potential in these children will do no one any good unless they are put to work in the local communities where the children live.

From the 1963 report of the Child Welfare Division, Colorado Department of Public Welfare, Denver.

IN THE JOURNALS

Poverty

The average total income per person of the 4 million people in the Federal-State program of aid to families with dependent children (AFDC) is $1.15 a day, a figure derived from 1961 data analyzed by Gerald Kahn and Ellen J. Perkins in *Welfare in Review* for October 1964. ("Families Receiving AFDC: What Do They Have To Live On?") This daily $1.15—about $35 per recipient per month and $140 for a family of four—must cover costs of food, shelter, fuel and light, clothing, personal care, transportation, school expenses, and other daily living requirements.

Thus the annual income from all sources of families receiving AFDC averages $1,680, little more than half the $3,000 figure used as the poverty demarcation line by President Johnson in his message on poverty.

"Of all public assistance recipients, AFDC families receive the least adequate public assistance payments" and "fall furthest behind in progress in American standards of living," the authors report. For example, during the 3-year period 1958–61, the annual income of AFDC recipients increased $36 per person, while the average per capita income for the Nation as a whole went up $34 every 6 months.

The authors point out that nearly half of all AFDC families have some unmet need under their State's own standards of minimum living costs; for a fourth of the families this unmet need comes to $30 or more a month; for almost 3 percent, to $100 or more a month.

Foster Home Variables

Based on a study of the records of one Montreal children's agency—the Children's Service Centre—H. B. M. Murphy, McGill University psychiatrist, concluded in the quarterly *Mental Hygiene* for October 1964, that suburban foster homes "achieve . . . much poorer results" than urban or rural foster homes, regardless of the sex or family background of the children placed in care. ("Foster Home Variables and Adult Outcomes.")

This study was the second in a series by Dr. Murphy, the first of which reported on 316 cases taken from the same agency. ("Natural Family Pointers to Foster Care Outcome," *Mental Hygiene*, July 1964.)

The second study reports on the foster-home histories of the 114 cases among these 316 whose natural backgrounds seemed to indicate the poorest prognosis, plus an additional 82 children, for comparison, whose natural backgrounds were apparently more favorable.

Although expecting that favorable adult outcome would depend on such factors as avoidance of multiple placements, a warm and loving foster mother, and clarity in explaining to the child his relationship to the various adults around him, the author concluded that the "variable which proved most strongly associated with outcome" proved to be the residential location of the foster home. "Poor risk" children spending their longest foster stay in a suburban home were shown to have a much higher percentage of unsatisfactory outcome than those spending their stay in either a city or a rural home.

Followup of Prematures

Some findings of a followup study of children born prematurely in a large municipal hospital serving families of low socioeconomic status are reported in the October 1964 issue of the quarterly *Social Work*. ("Development of Lower-Class Premature Children Born In and Out of Wedlock," by Helen Wortis, Rhoda Cutler, Rose Rue, and A. M. Freedman.)

The study involved 249 Negro children who weighed 2,100 grams or less when born at the Kings County Hospital in Brooklyn, N.Y., and who were followed through the premature clinic for 2½ years.

Findings on the child's developmental status and social situation at age 2½ were analyzed in relation to the mother's marital status at the time of his birth. While there was a high incidence of neurologic abnormality in the total group of children, no significant relation was found between the incidence of neurologic abnormality and the mother's marital status. In regard to social situation, however, the children born out of wedlock were reported as "more often separated from parents, more likely to be dependent upon public assistance and to have a working mother." On the other hand, the investigators found no difference by marital status of the mother in the quality of care a child was receiving at 2½ years.

Varied Roots of Delinquency

"What is a juvenile delinquent?" asks William C. Kvaraceus, Ph. D., in an article in the quarterly *Federal Probation* for September 1964, pointing out the differences from country to country in definitions of delinquency and in points of view on what should be done about it. ("Juvenile Delinquency: A Problem for the Modern World.") He maintains that in almost every city in the world an important element in the overall pattern of juvenile delinquency is the juvenile gang, and that serious acts of delinquency are being committed by the sons of the rich as well as of the poor.

The author cites three case stories to make the point that "delinquents often do the same thing for vastly different reasons." He recommends checking several scientifically evolved theories in dealing with each individual delinquent "apart from his conspirators." These are theories having to do with reactions to home life, school problems, relationship to parents, self-image, and personality, as well as those concerned with the patterns of behavior and the frustrations of the neighborhood milieu. The author's theme: "There is not one cause for delinquency but rather a sequence of interlocking factors in the child's life that can result in delinquency."

Dealing with the problem of delinquency, the author asserts, must be a concern of the whole community, involving not only schools, police, courts, job-training and employment services, but also the parents of delinquents and the delinquents themselves.

HERE AND THERE

Against Delinquency

Three grants, each of a different type, were made late in 1964 under the Juvenile Delinquency and Youth Offenses Control Act of 1961. (See "Federal Legislation," CHILDREN, November–December 1961, p. 232.) They were:

• **A community demonstration grant** of $1.5 million to the United Planning Organization (UPO), in Washington, D.C., an organization incorporated in December 1962 to provide opportunities for youth in the District of Columbia, and recently designated as coordinator for the "war on poverty" in the District. The grant is the first portion of $5 million to be awarded under a special provision of a 1964 amendment to the act for a delinquency prevention demonstration program in the Nation's Capital. The money will be used to carry out the plans made by Washington Action for Youth (WAY), a division of UPO, for a multifaceted project in the low-income, densely populated Cardozo area of Washington, part of which had already been put into operation with the support of a pilot demonstration grant. (See "For Youth," CHILDREN, November–December 1963, p. 242.)

The UPO project includes: a youth employment program, with emphasis on training, placement, and on job development; a neighborhood development center providing community organization, consumer education, and services—credit union, legal aid, and family counseling; residential facilities—halfway houses, shelters, group foster-family homes for children and youth needing care away from home; day-care centers for preschool children; research evaluation.

• **A training grant** of $50,216 to the University of Hawaii, for the first year's operation of a 3-year experimental delinquency control and prevention training center at the university. The center will develop comprehensive and specialized programs for the further training of teachers, social workers, law enforcement personnel, and others who work with youth; test the applicability of techniques of delinquency control developed elsewhere and supplement these with others to be developed locally; train volunteers to work with underprivileged youth; develop training materials; and carry out evaluative studies. The center's faculty will be made up of persons from the fields of sociology, social work, education, psychology, political science, and other related disciplines.

• **A new type of short-term demonstration grant,** the first of a number to be made for direct service to delinquents or potential delinquents. The grant of $43,297 went to the University of California at Berkeley for work in the public schools to build on the strengths, cultural and personal, of children identified as troublesome by their teachers.

Rights of the Poor

The need for a team approach between lawyers and social workers to protect the legal rights of the poor received strong emphasis in the discussions of a 3-day conference on the extension of legal services to the poor, held in Washington, D.C., in mid-November under the auspices of the Office of Juvenile Delinquency and Youth Development, Welfare Administration. Of the 158 participants, about two-thirds were lawyers, many of them on the faculties of law schools or schools of social work, and the rest were social workers or persons closely connected with the work of social agencies. While recognizing the differences in perspective and training that create misunderstandings between the two professions, they considered the possibilities of working more closely together to use the law as an instrument of social change and protection.

In welcoming the conferees, Ellen Winston, Commissioner of Welfare, pointed to three reasons why it is important to find more effective methods of meeting the legal problems of the poor: (1) In many communities, measures for helping the poor with their legal problems are meager or nonexistent; (2) lack of educational advantages makes many poor people susceptible to injustice and exploitations; (3) with the growth of the population and resultant increasing complexity of laws and regulations, there are more occasions to need legal services.

Throughout the conference, repeated references were made to the fact that many of the poor are kept poor because they do not know their legal rights in relation to such problems as installment buying, landlord-tenant differences, public welfare administration.

"The poor," said Acting Attorney General Nicholas deB. Katzenbach, at the luncheon meeting, "need advocates, not simply to present their side of the story but to give them hope, to demonstrate that the law is not an enemy, but a guardian, and that public officials are not their masters, but their servants."

Panel presentations and discussions from the floor and in three workshop groups revealed considerable interest in community experiments in (1) providing aggressive neighborhood-based legal services and in (2) law school experiments in providing legal service to the poor through supervised student "interns."

The neighborhood-based legal services go beyond the usual community-supported legal aid service, it was pointed out, by making efforts, through a lawyer-social worker partnership, both to find cases needing legal help and to prevent the need for such help by educating the people in the neighborhood as to the requirements of, and their rights under, laws and regulations which affect their daily lives.

The use of law student interns was described not only as a needed extension of legal services to the poor, but as a valuable method of interesting young lawyers in social problems and social needs.

Frequent reference was made to the need on the part of both lawyers and social workers for training in the basic goals and philosophy of each other's profession.

The misunderstandings of social workers and lawyers usually occur, it was maintained, because of the failure of lawyers to understand the weakness of the adversary system in dealing with social problems, and the failure of social workers to adhere to the rules of evidence when serving as factfinders for the court. The adversary system, it was charged, fails to protect children who are used as pawns in divorce proceedings, and is abrogated completely

in juvenile courts, "where the child's only hope that the truth will be brought out rests on the social worker."

Full proceedings of the conference will be published in the near future by the Office of Juvenile Delinquency and Youth Development.

Training Opportunities

A 3-year career development program in maternal and child health for physicians, leading to certification by the American Board of Pediatrics as well as to a degree of master of public health, has recently been initiated by the University of California School of Public Health at Berkeley in conjunction with the pediatrics department of the university's medical school at San Francisco and the medical schools of Stanford University and the University of Washington. Fellowships are provided by the Children's Bureau.

Two other new training programs recently initiated by the University of California School of Public Health at Berkeley are:

- A 12- to 17-month training program in school health for physicians, nurses, and health educators. The program is offered by the school's Divisions of Maternal and Child Health, Public Health Nursing, and Health Education. Fellowships funded by the U.S. Public Health Service are available.
- A 2-year educational program in mental retardation and related conditions, sponsored by the Children's Bureau, to train pediatricians to "plan, direct, administer, and operate community services for children with mental retardation and associated abnormalities." The program is divided into two parts: 9 months at the School of Public Health where the student majors in maternal and child health; 15 months of intensive clinical training in a variety of clinical services in the Bay Area. Fellowships are available.

Polio Reductions

Marked decreases in the incidence of poliomyelitis in an 11-year period (1951–62) covering the introduction of antipolio vaccine are shown by figures recently released by the World Health Organization for 28 countries which report the disease to WHO.

In the decade between 1951 and 1961, yearly case reports in Norway decreased by 97 percent—from 2,233 to 66. In the same decade, cases in the United States declined by 95 percent—from 28,386 cases in 1951 (and 57,879 in the epidemic year 1952) to 1,312 in 1961.

For other countries with a high incidence of cases in 1952, comparisons are given with 1962 reports: Denmark, with 5,676 cases in 1952, dropped to 14 cases in 1962; the Federal Republic of Germany, from 9,540 to 291; New Zealand, from "almost 900" to 3.

Reductions from 1951 to 1962 noted in the report are: Mexico, 1,834 to 483; Israel, 918 to 16; Japan, 4,233 to 287; Australia, 4,736 to 435.

Not one case was recorded in Czechoslovakia in 1961 or 1962, although 1,074 cases had been recorded there in 1957. Canada, which had 8,888 cases in 1953, had 89 cases in 1962. Switzerland, with 1,628 cases in 1954, had 12 cases in 1962.

Although the general trend in incidence was downward, two countries reported increases. In the United Arab Republic, the only African country reporting, cases increased from 18 in 1951 to 234 in 1962, with peaks in 1955 and 1958. In Ceylon, there were 212 cases in 1951 and 1,952 in 1962. In both countries, vaccination campaigns are in progress.

The WHO report warns against comparing the figures from different countries, since, because of its wide range of symptoms, poliomyelitis is not always recognized and since some countries report only cases with paralytic manifestations.

Day Care

A 3-day National Conference on Day Care Services is to be held in Washington, D.C., May 13–15, 1965, under the sponsorship of the National Committee for the Day Care of Children and the Child Welfare League of America, in cooperation with the Children's Bureau. The conference is designed to interpret the day care of children as an essential community service for strengthening and maintaining family life, and to promote community action throughout the country for the development of day-care services. Representatives of business, industry, labor, and professional groups in a position to influence the development of day care are being invited to attend.

. . .

A general lack of awareness of the State child-care licensing program was found among employed mothers interviewed in a recent survey of day-care arrangements and needs in Topeka, Kans. The survey was sponsored jointly by the Division of Maternal and Child Health, Kansas State Department of Health, and the Topeka Welfare Planning Council. Information was gathered through interviews with a selected sample of families from all parts of the city; and through inquiries to agencies serving families and children.

Other findings were that—

- Among children of working mothers, the largest group consists of those cared for by relatives; the second largest, of unsupervised school-age children.
- A greater proportion of Negro children than white children need day-care services and such services are less available to them.
- Many handicapped or culturally deprived children known to social agencies need experiences away from home, which they are not now getting.

The study recommends: the extension or expansion of day-care services of all types—part-time and full-time care for preschool children, foster family care for children under 3, after-school care for school-age children—with subsidized care being made available in low-income neighborhoods; special efforts to educate the public about the child-care licensing program; and the establishment of an interagency board to arrange for appropriate day-care placement of individual handicapped or culturally deprived children.

The report of the study, "Day Care of Children: a Survey of Day Care Needs in Topeka, Kansas," is available from the Division of Maternal and Child Health, Kansas State Department of Health.

. . .

A project to demonstrate and assess the usefulness of social casework in connection with day-care service is under way in Worcester, Mass., under the sponsorship of the Catholic Charities of the Diocese of Worcester. The project is being supported by a grant from the Massachusetts Division of Child Guardianship with the use of Federal day-care funds made available through the Children's Bureau.

By placing social caseworkers for 8 months in two day-care centers to provide direct, consultative, and educational services and, at the end of the

period, eliciting observations from day-care personnel and parents, the project will attempt to identify and evaluate: (1) methods for interpreting the values of casework service to day-care personnel and parents using day-care service; (2) the range of other social welfare services required by families using day care; and (3) alternative ways of organizing social services for families using day care. One of the day-care centers participating in the study is an agency-sponsored center; the other is a commercial venture.

The service aspects of the project, which got under way in September 1964, are scheduled for completion by June 1965.

. . .

A national survey of the child-care arrangements made by working mothers will be conducted by the Bureau of the Census in February 1965 as part of its monthly Current Population Survey. Jointly sponsored by the Children's Bureau and the U.S. Department of Labor, Women's Bureau, the survey is planned to update a similar survey sponsored by the Children's Bureau in 1958. (See "Day Care," CHILDREN, March–April 1959, p. 77.) While the 1958 survey included only children under 12 whose mothers were working full time, the new survey will include children up to 14 whose mothers are working either full or part time.

Child Welfare Research

Differences between home and day-care settings may have more significant developmental effects on children who experience day care, than differences between the child-rearing practices of mothers and of day-care personnel, according to an exploratory study recently made in Los Angeles County, Calif. The investigators suggest that the regulatory features inherent in group care offer fewer opportunities than do home settings for children "to test the limits of their skill and competence, to reject temptations, to observe adult roles, or to talk with adults." They found marked similarities in child-care goals among mothers and day-care personnel, although some differences—especially between the centers and mothers of low socioeconomic status—in attitudes toward timing and initiative and in training and enforcement patterns.

The study, "Children in Group Day Care: The Effect of a Dual Child-Rearing Environment," was undertaken by the Welfare Planning Council of the Los Angeles Region, with Federal funds from the Children's Bureau. Its purpose was "to develop a more precise formulation of those elements which determine the outcomes of day-care experience for preschool children."

The investigators sought answers to three questions: (1) What alterations in the child-rearing environment occur for all children who are placed in group day care? (2) Are the alterations greater for some children than for others because of their family backgrounds? (3) To what extent does the choice of a particular type of day-care center alter the child-rearing environment?

From the 396 day-care centers which in Los Angeles County provide full-day care for children of working mothers, 30 were selected for observation by the investigators. These were chosen on the basis of their type of sponsorship (public, private nonprofit, or commercial) and the socioeconomic and dominant ethnicity of the neighborhoods, so that they would be representative of the various types of centers in the community.

Interviewers questioned 219 mothers and 67 teachers as well as the centers' 30 directors.

In analyzing the results, the investigators divided the parents into four groups according to socioeconomic status (SES) based on combined ratings of mother's education, mother's occupation, and total family income. The centers, and the parents, were also classified according to "climate": warm nonauthoritative; warm authoritative; cold nonauthoritative; cold authoritative.

Among many other findings, the investigators report that:

- Parents on the whole are more likely to punish by spanking, whereas teachers are more likely to use restriction as a method of enforcement; teachers place more restriction on noise than do parents.
- Teachers as a group have higher standards than parents for neatness and table manners, and place more emphasis on the care of property. Parents have higher standards for their children in areas of behavior with "moral connotations"—sexual curiosity, bad language, aggression.
- Parents, especially those of low SES, expect children to obey more quickly than teachers.
- Authoritative mothers frequently place their children in nonauthoritative centers; and nonauthoritative parents often place their children in authoritative centers.
- Parents with the lowest demands for independence (low SES parents) are most apt to place their children in "cold" centers, where demands for independence are high.
- The director's educational attainment appears to have important consequences for the center's climate, its program development, the quality of supervision, and sureness in administrative leadership. Well-educated directors are most apt to have warm, but not necessarily well-educated, persons working under them as teachers.
- Program and climate in centers appear to be responsive to the presence or absence of parental demands and expectations. When parents expect nothing more than custodial care, the program is likely to drift in that direction.
- Mothers' usual "intuitive" child-rearing patterns often appear to be disrupted when contact with the child is telescoped into a small portion of the day. Low SES mothers who work tend to have fewer opportunities than working mothers of higher SES to be with their children, since they place their children in group care at a younger age and the children remain in care for longer hours.
- Low SES homes are less apt to provide the child with the dimensions of experience which seem to be lacking in group care—especially opportunities to develop initiative and language skills.

Against Measles

The U.S. Public Health Service has begun immunization against measles of 4,500 Alaska native children (Eskimo, Indian, and Aleut) under 4 years old, using the new "live attenuated" vaccine, which is expected to immunize for life. This is the same vaccine being used in the program to immunize 1 million African children being conducted in six West African countries, with the assistance of the Agency for International Development. (See "Vaccines," CHILDREN, November–December 1964, p. 243.)

The Alaska program got under way in

July 1964 and is expected to be completed by June of 1965.

USPHS staff are assisted by nurses of the Alaska State Division of Public Health under a contractual arrangement with the Federal agency. Health teams take off by bush or chartered planes from one of the seven Alaska native hospitals operated by the USPHS. After the planes land, the medical supplies often are transported from village to village by dogsled, skin boat, and/or snow cart.

Measles is the leading contagious disease among Alaska native children, who tend to suffer more severely from serious complications than do most other American children.

In the development of the live attenuated vaccine, children of both Africa and Alaska played an important part. In last year's pilot programs to test the newly developed live vaccine, Eskimo children in the villages of Hooper Bay and Chevak in the Bering Sea coastal area near the Arctic Circle participated, while children in the villages of Upper Volta, near the Equator in Africa, were doing the same. (See "About Vaccines," CHILDREN, July–August 1962, p. 166.) The vaccine was licensed by the U.S. Public Health Service for commercial output on March 21, 1963. (See "Vaccines and Drugs," CHILDREN, May–June 1963, p. 121.)

Following completion of the initial measles immunization programs in Alaska, measles vaccination will become a part of the USPHS's regular inoculation program for Alaska native children, which now includes immunization against polio, smallpox, influenza, diphtheria, whooping cough, and tetanus.

Child Health

The importance of early health care to the later health of children and youth is emphasized in a report of the health care of school-age children, submitted to President Johnson late in November by Secretary of Health, Education, and Welfare Anthony J. Celebrezze, as the result of a request made by President Kennedy in his youth message, February 14, 1963.

Prepared by the Children's Bureau, in cooperation with the Office of Education, the Public Health Service, and the Office of the Commissioner of Welfare, the report presents data on the prevalence of illness and handicapping conditions among children of various ages and economic groups, and on the availability and use of medical facilities for their care, and describes changing concepts of school health services.

Pointing out that the roots of many health problems among school children reach back to early years of childhood in an environment of emotional, intellectual, and economic deprivation, the Secretary in his letter of transmittal stressed six areas of needed action revealed by the report. In brief, they are:

- The resources of agencies concerned with welfare, health, and education should be brought to bear on the child's problems early in the preschool years.
- Renewed emphasis should be given to clinics providing child health supervision, with experimentation in the most effective use of physicians, public health nurses, and others.
- Programs should be developed to test the effectiveness of different methods of identifying children with health problems.
- Comprehensive screening projects encompassing several schools should be developed and clinics be made available to which children, with their parents, can be referred.
- Greater emphasis should be placed on health programs for children in secondary schools, especially through the development of clinics for adolescents.
- Studies and demonstrations should be made to test methods of reaching and screening preschool children for vision and hearing problems.

The report, "Health of Children of School Age" (Children's Bureau Publication No. 427, 1964), is available from the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402; price, 25 cents.

Mental Retardation

In mid-November, the Children's Bureau announced grants totaling $1,456,736 for 15 projects in maternal and child health and crippled children's services, the second group of awards made under the increased appropriations and new programs authorized by the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act. (See "Health Grants," CHILDREN, September–October 1964, p. 199.)

Included is a grant of $826,575 to the Puerto Rico Insular Department of Health to establish a program of prenatal, delivery, and post-partum care for mothers and infants in the island's Ponce area—the eighth project in the new maternal and infant care program.

Of the remaining 14 grants, 10 were made to provide special training for physicians, nurses, and occupational therapists in pediatric care and mental retardation; and 4 to provide additional clinical services for children with mental or physical defects, or both. They went to 11 universities, a city health department, a children's hospital, and a State school for the retarded.

. . .

In mid-October, the Public Health Service awarded the first two of a number of Federal grants for construction of large-scale mental retardation research and training centers under the provisions of the "Mental Retardation Facilities and Communities Mental Health Centers Act of 1963." The recipients were the University of Washington School of Medicine in Seattle ($6,040,000) and the Albert Einstein College of Medicine of Yeshiva University in New York ($3,750,000).

The grants will provide about 75 percent of the anticipated cost of constructing the two centers, which are expected to be completed in 1968. Each university has pledged that it will use its center for research and training for 20 years.

. . .

A national advertising campaign to alert the public to the needs and potentials of the mentally retarded was launched late in 1964 under the joint sponsorship of the Joseph P. Kennedy, Jr. Foundation, the U.S. Department of Health, Education, and Welfare, and the Advertising Council, a private, nonprofit, public service organization supported by business groups. The campaign began with the distribution of "advertisements" and spot announcements prepared by the Advertising Council to newspapers and to radio and television stations, to be carried as a public service. Costs of preparing and distributing the material are being shared by the Kennedy Foundation and the Department. The National Association for Retarded Children is underwriting the costs of printing a pamphlet being distributed in conjunction with the campaign.

READERS' EXCHANGE

HROMADKA: *Training child care workers*

Van G. Hromadka's article deserves much attention. ["How Child Care Workers Are Trained in Europe," CHILDREN, November–December 1964.] The training of child-care workers is an urgent matter.

The principles Mr. Hromadka expresses are excellent: (1) The need for respect for child-care workers and the establishment of equal status with other professionals; (2) the need for comprehensive training programs; (3) the treatment of the child as a child regardless of his handicap; (4) the equal treatment of residential care and care outside the residence. However, his contention that all this is available in Europe or at least in the countries he studied is a misleading generalization.

Certainly there are some places in Europe which have the kind of training Mr. Hromadka describes and where child-care workers are accepted as equals. Yet the status, even of professionals working in the child-care field, such as social workers and educators, is in many European countries so low that children in institutions suffer under practices which are the same as or worse than those found in many institutions here.

The fact that child-care workers receive 2 years of training says little about the quality of training. Many persons concerned with European institutions are painfully aware of their incredibly low standards, as we are of the low standards in some of our institutions in this country.

Perhaps it is not so important to discuss specific programs as it is to develop thinking about a realistic, possible and effective training for child-care workers. Mr. Hromadka's suggestion of a curriculum goes far beyond what is possible in a reasonable period of time, but it does give a basis from which to start. Actually, it reads like the curriculum offered to social group workers in American schools of social work, with some additions—a curriculum which requires in the United States at least 2 years of graduate study following 4 years of college. Can this be demanded realistically of all child-care workers?

Mr. Hromadka's call for a reassessment of child-care programs and the training of child-care workers must be heard, whether or not one agrees with all his facts.

Gisela Konopka
Professor, School of Social Work, University of Minnesota

Author's reply

Dr. Konopka refers to my "misleading generalizations," yet, to support her comments, she herself makes broad general statements. If I were to express my personal impressions gained overseas, I might agree with her that, from our concept of treatment, some European institutions would rate rather low, and that, on the whole, the social workers in this country enjoy a more thorough training and higher status than most of their European colleagues. However, neither the social work profession nor institutional treatment programs were subjects of my reporting.

I made it clear I was in no position to assess the qualitative results of the training discussed. My "contention" was simply to stimulate our own thinking about professionalization of child-care workers by sharing a few pieces of evidence that in some parts of Europe this idea has already taken a more definite shape.

It is erroneous to imply that I am suggesting "European" curriculum as a cure for our problems of training child-care staff. I am too well aware of the cultural implications involved to think that what may work in other countries must necessarily work here. Also, I do not believe that any sound new curriculum should be created without having first the facts about the actual and expected tasks of those to be trained and about the training presently provided. The human material to be trained is, of course, another phenomenon to be assessed.

In regard to the curriculum reading "like the curriculum offered to social group workers . . . with some additions," it is these "additions" that I tried to point out and which I see important to take into account.

Van G. Hromadka
Research Director, Professional Child Care Project, Jewish Board of Guardians, New York

EISENBERG: *Author's reply*

Dr. Lauretta Bender and I differ less on questions of fact than we do on matters of philosophy. [See CHILDREN: "Role of Drugs in Treating Disturbed Children," by Leon Eisenberg, September–October 1964; and "Readers' Exchange," November–December 1964, p. 244.] When she states "drugs must always be a part of a treatment program, and one should know what kind of child is being treated with a specific medication," I could not agree with her more heartily. But her disavowal of "treating children with placebos and blindly" seems to me to misconstrue the very nature of therapeutic research.

It is true that many important therapeutic contributions have been made on the basis of clinical observation and that subsequent controlled studies have done nothing more than to establish the validity of the original observations. However, the literature is also replete with examples of conclusions arrived at by uncontrolled clinical studies which proved to be incorrect both by the criteria of further clinical experience and by controlled trial.

As to toxicity, in our experience jaundice has followed the use of chlorpromazine in children, though rarely. The extrapyramidal syndromes can produce great distress in child and parents and can be all too easily confused with other medical conditions if the child comes to the attention of a physician not aware that the patient is under medication.

Dr. Bender has expressed a point of view which merits careful consideration. Whatever differences we may have about how to conduct therapeutic research, we would both agree that skillful clinical management on the part of an experienced physician who adjusts his treatment program to the needs of the individual child is the best guarantee of the proper and effective use of drugs.

Leon Eisenberg, M.D.
Professor of Child Psychiatry, The Johns Hopkins University School of Medicine

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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PUBLICATIONS OF THE CHILDREN'S BUREAU. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. October 1964. 33 pp. Single copies available from the Bureau without charge.

This booklet lists all the Children's Bureau publications that are available for general distribution—those directed to parents, to teenagers, and to professional persons. Order blanks are included.

GOALS, PROBLEMS, AND PROGRESS IN CHILD WELFARE: report of four regional meetings on implementation of the 1962 public welfare amendments. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. Child Welfare Report No. 13. 1964. 99 pp. Single copies available from the Bureau without charge.

This report summarizes the content of four regional meetings of State child welfare directors called by the Children's Bureau between mid-November 1963 and late January 1964 to discuss plans for implementing the new emphases for child welfare services identified in the 1962 amendments to the Social Security Act—extending services to all political subdivisions of the State by July 1, 1975; reaching all children in need of services; and expanding and improving day-care services within the public child welfare program.

MAPLE SYRUP URINE DISEASE. HISTIDINEMIA. Two fact sheets on each disease, one for professionals, and one for laymen. Jane S. Lin-Fu, M.D. Department of Health, Education and Welfare, Welfare Administration, Children's Bureau. September 1964. Single copies free on request from the Bureau.

These fact sheets describe two diseases caused by inborn errors of metabolism. First described in 1954, untreated maple syrup urine disease (MSUD, maple sugar disease, or branched chain ketoaciduria) generally results in infant death or in severe mental retardation. Histidinemia, first described in 1961, usually results in a speech and language defect; it produces positive reactions to ferric chloride tests of urine and so may be confused with phenylketonuria. The descriptions report encouraging results in treating MSUD babies with a synthetic diet, but no known specific treatment for histidinemia.

DAY CARE FOR OTHER PEOPLE'S CHILDREN IN YOUR HOME. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 412. 1964. 17 pp. 15 cents.

This pamphlet offers suggestions to help day-care mothers who do not have the help of social agency supervision.

DIRECTORY OF HOMEMAKER SERVICES, 1963; homemaker agencies in the United States. Department of Health, Education, and Welfare, Public Health Service, Division of Community Health Services. PHS Publication No. 928. 1964. 324 pp. $1.50.

In bringing up to date a 1961 directory, this publication lists and describes the service policies of 303 agencies which administer homemaker programs in 44 States, the District of Columbia, and Puerto Rico.

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